

[Senate Hearing 110-]
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MILITARY CONSTRUCTION AND VETERANS AFFAIRS, AND RELATED AGENCIES
APPROPRIATIONS FOR FISCAL YEAR 2008

THURSDAY, APRIL 12, 2007

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, DC.

The subcommittee met at 10:12 a.m., in room SD-124, Dirksen
Senate Office Building, Senator Jack Reed presiding.

Present: Senators Reed, Byrd, Murray, Hutchison, Craig, and
Allard.

DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF R. JAMES NICHOLSON, SECRETARY
ACCOMPANIED BY:

MICHAEL J. KUSSMAN, M.D., ACTING UNDER SECRETARY, VETERANS
HEALTH ADMINISTRATION
WILLIAM F. TUERK, UNDER SECRETARY FOR MEMORIAL AFFAIRS,
NATIONAL CEMETERY ADMINISTRATION
ROBERT J. HENKE, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT
OF VETERANS AFFAIRS
ROBERT T. HOWARD, ASSISTANT SECRETARY FOR INFORMATION AND
TECHNOLOGY, DEPARTMENT OF VETERANS AFFAIRS
RON AUMENT, DEPUTY UNDER SECRETARY, VETERANS BENEFITS
ADMINISTRATION

OPENING STATEMENT OF SENATOR JACK REED

Senator Reed. Let me call this hearing to order.

And, this morning we're joined by the chairman of the full
committee, Senator Robert Byrd. And, I would like to, at this
time, recognize Chairman Byrd for his statement.

Senator Byrd, please.

STATEMENT OF SENATOR ROBERT C. BYRD

Senator Byrd. I thank you.

Mr. Chairman, in the fourth century Augustine of Hippo
said, ``In doing what we ought, we deserve no praise because it
is our duty.''

Mr. Chairman, over the last several years the
administration has repeatedly shirked its duty by sending
budget requests to Congress that have short-changed our
veterans. When the supplemental request was received a few
months back, there was no request for additional funding from

the Department of Veterans Affairs to treat those veterans who have been injured during the wars in Iraq and Afghanistan, including those injured who required special care and those who require long-term care.

To address these very pressing needs, the Senate recently added \$1.77 billion to the emergency supplemental appropriations bill. The continued neglect of America's seriously injured veterans demands an emergency response from Congress.

As the chairman of the full Appropriations Committee, I am at a complete loss as to why this administration does not feel the same way. While the VA continues to try to address the injuries and unique illnesses suffered by Vietnam and Persian Gulf war veterans, a new surge of injured warriors are flooding our veterans hospitals. Each conflict and each patient presents a unique dilemma. The VA must be ready to step up to the daunting challenge. The backlog of claims within the Department of Veterans Affairs remains unacceptable.

We continue to receive reports of veterans who are forced to wait far too long for an appointment. Now, I'll say that again. We continue to receive reports of veterans and from veterans and by veterans who are forced to wait far too long for an appointment. And, the number of veterans entering the system continues to grow at a rapid pace. The ongoing wars in Iraq and Afghanistan combined with a growing number of patients from previous conflicts have resulted in an unprecedented strain.

Attempts at seamless transition between the Department of Defense and the Department of Veterans Affairs date back to the 1980s. And, while billions of taxpayer dollars have been invested in the development of electronic medical record keeping standards in each agency, a reliable system has yet to be established.

In West Virginia, we received positive comments regarding the quality of care, but very negative comments regarding appointments to get that care.

I believe that these veterans, as a result of their service to our country, deserve the best possible care, not on your timeline, and I say this most respectfully, not on your timeline, but on theirs. And, we, meaning Robert C. Byrd and the members from both sides, we should do everything we can to ensure that their service and sacrifices are honored.

Mr. Chairman.

Senator Reed. At this point, I'd like to recognize the ranking member, Mrs. Hutchison, for her statement.

STATEMENT OF SENATOR KAY BAILEY HUTCHISON

Senator Hutchison. Mr. Chairman, I'm happy to defer to you for a statement first.

Senator Reed. I think in fairness we'll go back and forth, so why don't you go ahead now.

Senator Hutchison. Thank you. Thank you, Mr. Chairman.

I'm pleased to welcome the Secretary and the other witnesses and guests today, because we all know this is a very important subject and the budget that you have presented is certainly one that we must appropriately address.

The medical services account is up 6.49 percent and medical administration requests up 8.49 percent and this is necessary growth to keep pace with the increasing workload. That is in addition to over \$1.5 billion that we put in a supplemental appropriation to assure that you would have the money to meet the increasing demand from the, for the Veterans Affairs Medical Services. I am especially pleased to see the emphasis that you have placed on post-traumatic stress syndrome and the incidence of traumatic brain injury, which we will discuss further, I'm sure, but this is something that we see many of our returning soldiers dealing with, and that you have increased that part of your appropriations request is very good.

We also--I want to say that the \$3 billion committed to mental health services, I am seeing that commitment to the Centers of Excellence and Mental Healthcare certainly coming to fruition. At the Waco Veterans Center--which has been one of the three designated, the other two being in California and New York--we're seeing that the collaboration with research facilities at Baylor University, Texas A&M, Fort Hood Army Hospital, and the Mental Health Association from the State of Texas, the facility at Waco has become a critical cornerstone in providing quality care. And I think that we're going to see great benefits from that. And, I appreciate your working to make that facility one that I think is going to be a true Center of Excellence.

I also want to say that you have stepped up to the plate on gulf war syndrome. The research being done on that is very important for--not only today--but future warriors who will go into chemical or biological weaponry. I think it is important that we learn once and for all how the chemicals that we know our soldiers were exposed to, coming back with these symptoms, can be addressed. So, I appreciate that despite some of the chatter out there and some of the controversy, that you have remained committed to finding out what is the cause and therefore, what can be the cure.

Another area of concern for me, has been the inability of the VA and the Department of Defense to coordinate the electronic transfer of records. One of the things that the committee has done through the years with myself and Senator Feinstein in complete agreement, and the full committee chair and ranking member in complete agreement, has been that the VA has a great electronic transfer system of records. That was shown in Katrina when not one veteran had a lost record. Wherever that veteran ended up from New Orleans, their records were electronically transferred and that, that veteran got the care and the medicine that he or she needed.

However, the Department of Defense is not coordinated with the Veterans Administration so, we have found that there has been a disconnect when the returning veteran of today is trying to get into the Veterans' system from active duty service, and, we want to, we want to remedy that.

I'm going to introduce an amendment to the Defense appropriations bill to ensure that the DOD healthcare records become electronic, and compatible, with the VA. That will mean that you, within your parameters and laws, will have to work with the Department of Defense, but it will be in everyone's

interest that we improve that system.

In addition, the number of days of processing required for benefits has certainly come under scrutiny. We are concerned that the processing of claims now has an average of 177 days and I know that you are aggressively hiring claims examiners and that you are providing in this appropriation for more claims examiners. I hope that this will be a major focus of your administration going forward. Someone should not have to wait more than 30 days to have the claims processed and I hope that that is your goal.

I want to bring up in the major construction area. You've got, in this year's major construction request, \$341 million for one project. That is over 53 percent of your major construction budget. This is a project that has already had \$259 million appropriated for it, of which only \$53 million has been obligated since 2004. So, I have to ask the question, why you're tying up so much money into one project if you are not obligating the funds? This is Las Vegas. The project was originally scheduled to cost \$286 million. Last year, the project was projected to cost \$406 million and now, 4 months later, your staff is reporting that the cost has risen to over \$600 million. I understand that an additional 90,000 square feet has recently been added to the project after the design was complete and so, I want to, to have a little more exploration of that and particularly because I know that there is least one study of there for South Texas to have a Veterans' Administration hospital, and that Booz Allen Hamilton has been tasked to do that. We've waited for over a year for that report, but I'd just like a little more explanation about why the major construction funding seems to be taken up with a project that doesn't seem to be going forward, and seems to be increasing in the amount of the allocation to it.

So, I hope that we can address some of these issues, but in the main, Mr. Secretary, I want to say that as the former chairman and now ranking member of this subcommittee, I appreciate how hard you have worked to be transparent with this committee, to address the issues of concern that we have had with our different chairmen and ranking members. Your staff has been very accessible and when you had the shortfall, you stepped up to the plate, you didn't try to, you didn't try to soften that there was going to be a shortfall. You came right to the committee, you asked for the help, and you got it. So, I appreciate the working relationship that we've had.

PREPARED STATEMENT

I appreciate the great job that veterans believe that you do, even with some of the things that I've talked about. The veterans are coming for veterans' healthcare in droves. The numbers are increasing exponentially. So, you are doing a good job in many areas and we want to make sure you have the funding you need to do the good job and to grow and do an even better job.

Thank you very much.

[The statement follows:]

Prepared Statement of Senator Kay Bailey Hutchison

Thank you, Mr. Chairman. I am pleased to welcome Secretary Nicholson and our other witnesses and guests. Today, we will examine the President's budget request for the Department of Veterans Affairs, including funds for veterans' benefits, healthcare, and national cemeteries.

There has been a lot of public concern lately about the ability of the Department of Veterans Affairs to deliver on its promises to America's veterans. This budget entrusts \$84 billion to the Department of Veterans Affairs to provide healthcare and benefits for our veterans. This is \$45 billion in mandatory benefits and \$39 billion for discretionary spending, which includes \$37 billion for medical programs.

The Medical Services account request is up 6.49 percent to \$1.656 billion and the Medical Administration request is up 8.49 percent to \$265 million. I know this growth is necessary to keep pace with the increasing workload you are taking on and we will do everything we can to work with you to take care of our Nation's veterans. We are concerned that as our brave men and women return from the war they receive the very best medical care our Nation can provide. I am please to see that your budget request keeps us on that track. I know it is difficult to anticipate every need, but I know this subcommittee is solidly behind providing everything you need to carry out your mission.

As more of our soldiers return with delayed Post Traumatic Stress Syndrome (PTSD) and the incidence of Traumatic Brain Injury is at an alarmingly high rate, I am please to see the emphasis you placed on these problems in you budget request. I'm sure we will discuss these issues at length today.

We are pleased to see that you have submitted all VA facilities to a thorough review to make sure there is no Building 18 in your system; and we are happy to find out there is not. Still, we recognize that our duty to veterans goes beyond buildings. It goes straight to the people and processes that ensure excellence in the spectrum of health, benefits, and memorial affairs.

We are pleased to see that \$3 billion has been committed to mental health services, including PTSD. The Waco Center of Excellence in Mental Health is a model for how consolidating personnel, training and specialized resources produces world class care. Their work includes close collaboration with the research facilities at Baylor University, Texas A&M University Medical School, Fort Hood Army Hospital, and the Mental Health Association from the State of Texas. The facility at Waco has become a critical cornerstone in providing quality care to our veterans and it is one of the many success stories for the VA. The VA is receiving great benefits from this hospital. I appreciate the work you have personally done for this facility and the other two in California and New York.

I am also pleased that collaborative research into Gulf War illness has continued for a second year, and I ask your assurance that this \$15 million annual investment continues for the sake of our deserving veterans. I appreciate the efforts you and your staff have made to make the collaborative agreement between the Dallas VA Medical Center and the University of Texas Southwestern Medical College a win-win for the VA, UT and especially our veterans. We do not yet understand all of the factors that have caused serious health problems for our veterans who fought in the Gulf region but we are seeing the many affects. I am committed, as are you, to not turning a blind eye to veterans who may have suffered harm during either of the Gulf Wars. Instead, we will

actively seek to understand and treat the service connected illnesses of our Gulf War veterans, whatever their cause.

We look forward to the good work you will do as the Chair of the Task Force on Returning Global War on Terror Heroes. We trust that as you examine the system of care for our wounded veterans, you will take every opportunity to break through old agency processes to coordinate easily accessible and effective care for our veterans. There is no excuse for allowing bureaucratic barriers, especially between DOD and the VA, to get in the way of caring for our service men and women's needs.

Electronic healthcare records proved how valuable they are during hurricanes Katrina and Rita. Because of the VA's great electronic healthcare system, not one veteran went without healthcare. You have said many times the VA has become the ``gold standard'' for its use of electronic healthcare records, and I think we all agree with you. While you are chairing this new task force I hope you are able to convince the Department of Defense not to develop records systems in parallel that do not build on your proven successes.

Another area of concern for me is the inability of the VA to receive medical records from the Department of Defense automatically and electronically. I understand you are cooperating in a pilot program with the DOD to test the bi-directional transfer of records. We cannot afford to wait too long for a solution to this problem. Not only does this jeopardize healthcare, it physically slows down claims processing times, and we are very aware of the large backlog of claims.

We are concerned that the average number of days to process benefits claims has risen to around 177 days instead of dropping to 160 days, as originally estimated for 2007. We don't want our veterans waiting over 30 days to have their claims processed. We recognize that you have aggressively hired 580 claims examiners over the past 2 years, and now you need even more. But, we are concerned that the inability to electronically transfer medical records and the IT system and management processes designed to help process claims are not as good as you or we would want them to be.

I will introduce an amendment to the Department of Defense appropriations bill to insure DOD healthcare records become electronic and are compatible with and easily transfer to the VA for a real seamless transition. In addition, we will then look to you to streamline your processes within the law, set explicit efficiency goals, and hold staff and contractors accountable to these high standards of productivity. We must improve the wait times for claims processing. That will be one of the major issues before this subcommittee.

Another issue that has been discussed many times on this subcommittee is VA's major construction plan. I particularly note that in this year's major construction request you ask for \$341.4 million for one project. This is over 53 percent of the entire major construction budget. This project already has \$259 million appropriated for it, of which only \$53 million has been obligated since 2004. Why tie up so much money into one project if you are not obligating the funds? Is this realistic? This project was originally projected to cost \$286 million. In November of 2006 your staff reported the project was then projected to cost \$406 million. Now 4 months later your staff reports the cost has risen to over \$600 million. This can't be all inflation and construction demand. I understand that an additional 90,000 square feet has recently been added to the project, after design was complete, and according to your architecture contractor the

original plan we approved was not realistic. I hope you will speak to this in your remarks, as I would like more information on your plans.

Mr. Secretary, last year I asked you to evaluate the inpatient healthcare needs of the South Texas Valley region. I understand you contracted for this study but it has been a year and I am still waiting for the results. Would you please advise me when I can expect the results from this study?

I look forward to discussing these and other issues with our witnesses. Thank you, Mr. Chairman.

Senator Reed. Thank you, Senator Hutchison.

I have a prepared statement, but I think Senator Byrd made a very compelling case and I'd be prepared to submit my statement to the record. And, I know that there's a hearing going on simultaneously involving Veterans' Administration and we want to, I think, move quickly to questions. I presume my colleagues have no formal statements at the time.

PREPARED STATEMENTS

Senator Craig. I'll make a statement in my questioning period.

Senator Allard. I'd just, Mr. Chairman, I'd just like to have my statement made a part of the record.

[The statements follow:]

Prepared Statement of Senator Jack Reed

Mr. Secretary, thank you for appearing before the subcommittee today to discuss the President's fiscal year 2008 budget request for the Department of Veterans Affairs. We welcome you and your associates, and we look forward to your testimony.

I believe that the Department of Veterans Affairs is at a critical point. Two years ago, Congress and the Nation got a sobering wake up call when the VA owned up to a \$3 billion shortfall in medical funding due to faulty budget projections. While the rest of America was focused on the growing number of casualties from the wars in Iraq and Afghanistan, the VA apparently neglected to factor them into its projections, thus leaving a gaping hole in its budget.

Congress moved swiftly to remedy that shortfall, and since then, we have been watching the VA budget very closely, as I'm sure you have noticed. I commend you for sending up a more realistic budget request last year, and again this year, and I believe that the VA is moving in the right direction.

Unfortunately, I do not believe that the VA is moving fast enough or aggressively enough to meet the challenges that are bearing down on it. Two weeks ago, the Senate passed a war supplemental funding bill that included \$1.7 billion for the VA, primarily to meet the unique medical needs of Iraq and Afghanistan war veterans. The House passed a similar measure. The need for such funding seems obvious to me, and yet the President did not request one penny in the supplemental for Iraq and Afghanistan veterans.

It is difficult to comprehend how the President and the Department of Veterans Affairs can reach the conclusion that no supplemental funding is needed for Iraq and Afghanistan veterans in the face of what has become the longest and costliest conflict for U.S. troops since Vietnam. No matter how you crunch the numbers, they just don't add up.

Hundreds of thousands of new combat veterans are entering the VA healthcare system, some with catastrophic injuries that will require life-long care, and yet the Administration seems to think these veterans can simply be absorbed into the system without a major reassessment and reinforcement of the VA's budget.

That is a perilous assumption. It is essential for the VA to prepare for the future now, not when the next crisis is upon us. We have all seen the reports in the media about the rundown facilities and substandard treatment of some of our wounded service members at military and VA hospitals. I am pleased that both the Defense Department and the VA are moving to address these issues. We know there are problems today, and it is no great stretch to recognize that these problems will only grow worse if they are not addressed quickly and comprehensively. This is not the time for penny-wise, pound-foolish budget decisions. I fear that the President's budget request for fiscal year 2008, while adequate to keep the VA afloat today, is dangerously shortsighted in terms of building the capacity that our veterans will need in the years to come.

Although we may not always agree on policies or priorities, it is important to remember that we are all committed to helping our Nation's veterans. Mr. Secretary, we want to work with you, and we ask you to work with us. We had some problems during the drafting of the supplemental in getting timely and accurate information from the VA to verify certain data and statistics. I would like your personal assurance that your agency will cooperate fully with congressional requests for this type of data in the future so that we can tackle these very important issues together.

There is much more that I could say, and would like to say, about the pressing needs of our Nation's veterans. But as you know, Mr. Secretary, there is a joint hearing of the Senate Armed Services and Veterans Affairs Committees underway at this time on disability and transition issues affecting both DOD and the VA. Many members of this panel who are also members of those committees, and I expect that many of our members would like an opportunity to attend that hearing as well. So in the interests of time, I suggest that we limit opening statements to the Chairman and Ranking Member, and I would ask that you keep your opening remarks brief so that we can get directly to our questions. We will, of course, include your full statement in the record, as well as the opening statements of any members who wish to submit them.

Thank you again for appearing before the subcommittee today.

Prepared Statement of Senator Wayne Allard

Thank you, Mr. Chairman, for holding this important hearing today. I appreciate all of our witnesses appearing before the committee today, and would like to especially welcome Secretary Jim Nicholson, a long time friend and fellow Coloradan.

This committee continues to face the challenges of balancing both the needs of veterans returning from combat in Afghanistan and Iraq as well as those who served their country in World War II, Korea, Vietnam and Desert Storm. As every day passes and more veterans return home, greater stresses are brought upon the Veterans Health Administration.

Despite the excellent quality of care provided by the VA, there have been a number of incidents over the last year that have reflected

poorly upon the military and veterans health systems. It is my hope that Congress can continue to work with the VA to ensure that the needs of all of our veterans are met and that they continue to receive exceptional care.

Of course, accomplishing these objectives is not easy if we also intend to reign in Federal spending and act fiscally responsible. These are the challenges that await, and I look forward to working with the panel to deliver to our veterans the quality healthcare they deserve.

Mr. Secretary, again I'd like to reiterate my appreciation to the panel for appearing in front of us today and I look forward to your testimony. Thank you Mr. Chairman.

Senator Reed. All statements were made part of the record upon submission.

And, at the request of Senator Byrd and we informed him, Mr. Secretary, we'd request you'd take an oath of your testimony. Please stand.

Senator Craig. Oh, you've got to be kidding me.

Senator Reed. Do you solemnly swear that the testimony you will give to the committee today is the truth, the whole truth, and nothing but the truth, so help you God?

Secretary Nicholson. I do.

Senator Reed. Thank you, Mr. Secretary.

Senator Craig. Mr. Chairman, in all due courtesy to the chairman of the full committee, since when did we start asking for oaths? I've never seen that practice in my 10 years of serving on the Appropriations--are we suggesting that the testimony that's about to be given is not truthful?

Senator Reed. No.

Senator Craig. Then why are we asking for an oath?

Senator Byrd. I'll tell you why.

Senator Reed. Mr. Chairman----

Senator Craig. Please do. This is a precedent-setting event, and it ought to be on the record.

Senator Reed. Mr. Chairman and Senator Craig for the record, we informed the Secretary. He had no objection to it. We informed the ranking member. She had no objection to it. I think it's the right of any member of the committee, with at least three members present, to request that any witness take the oath.

Senator Craig. I appreciate that.

Senator Reed. Those are the rules.

Senator Craig. Let the record show that I object, because I think it reflects an attitude of suspicion. Thank you.

Senator Reed. The record will so show that.

Secretary, your statement, please.

Secretary Nicholson. Thank you, Mr. Chairman, Senator Hutchison, members of the committee, Chairman Byrd.

I have a written statement that I would like to submit for the record.

Senator Reed. Mr. Secretary, your statement will be made part of the record. You can make a statement, a summary, or any----

Secretary Nicholson. Yes, sir.

Senator Reed [continuing]. Form thereof. Thank you, Mr. Secretary.

STATEMENT OF R. JAMES NICHOLSON

Secretary Nicholson. First, I'd like to introduce my VA colleagues that are at the table with me starting at my far left and your right is Under Secretary Bill Tuerk, who's the Under Secretary for Memorial Affairs. Next is Mr. Ron Aument, who is the Deputy Under Secretary for Benefits. My immediate left is Dr. Mike Kussman, who is the senior executive in charge of the Veterans Health Administration. My right and your left is Assistant Secretary Bob Howard, who's the Assistant Secretary for Information Technology. And, at my immediate right is Assistant Secretary Bob Henke, who is the Chief Financial Officer for the Department of Veterans Affairs.

I also would like to mention that, I like everyone else, is heartened to learn that Senator Johnson seems to be firmly on the road to recovery and we look forward to his return to the Senate and to our working with him to care for our veterans.

Mr. Chairman, I'm here today to discuss President Bush's landmark 2008 budget proposal of nearly \$87 billion for the Department of Veterans Affairs, which represents a 77 percent increase in veterans spending since this President took office on January 20, 2001. Medical care itself is up 83 percent.

This funding level allows for the VA to continue improving the delivery of benefits and services to veterans and their families in three critical primary areas.

One, to provide timely, high-quality healthcare to veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom. Veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs. To improve the delivery of benefits through the timeliness and accuracy of claims processing and to increase veterans access to a burial option in a National or State veteran cemetery. This budget will also allow us to continue our progress toward becoming a national leader in information technology and data security.

Mr. Chairman, I will outline the major portions of our proposed budget. The Veterans Health Administration, our total medical care request is \$36.6 billion in authority for our healthcare. VA healthcare is now almost universally acclaimed as the best healthcare in the world. During 2008, we expect to treat about 5.8 million unique veteran patients. We will see each of them on an average of 10 times, approximately, resulting in our seeing over 1 million patients per week.

With the resources requested for medical care in 2008, the Department will continue our exceptional performance, providing access to healthcare. Ninety-six percent of primary care appointments and 95 percent of specialty care appointments are scheduled within 30 days of the patient's desired date.

The President's request includes nearly \$3 billion to improve access to mental health services across the country. The VA is a respected leader in mental health and PTSD research and care. About 80 percent of the funds for mental health go to treat seriously mentally ill veterans, including those suffering from post-traumatic stress disorder. Our approach to PTSD is the, is to promote early recognition of this condition to prevent lasting impairment.

Medical research--the President's 2008 budget includes \$411

million to support VA's unparalleled medical and prosthetic research program. This amount will fund nearly 2,100 high-priority research projects to expand knowledge in areas most critical to veterans' particular health needs. Nearly 60 percent of our research budget is devoted to OIF/OEF healthcare issues.

In response to the unique injuries of the current war, the VA has expanded its four traumatic brain injury centers, which are in Minneapolis, Palo Alto, Richmond, and Tampa, to become polytrauma centers encompassing additional specialties to treat patients from multiple complex injuries. We're now expanding our polytrauma network to 21 sites and 76 clinic support teams around the country providing state of the art treatment closer to injured veterans' homes.

The VA has taken steps to raise awareness of TBI, that is traumatic brain injury, issues by requiring specific training on TBI. The course advises practitioners that brain trauma causes both acute and delayed symptoms and that prompt identification and multi-disciplinary evaluation and treatment are essential to successful recovery. On April 2, we began screening all OIF/OEF patients who come to us, to assess the possibility that they may have developed mild or moderate traumatic brain injury.

Seamless transition--one of the most important features of the President's 2008 budget request, is to make injured service members' transition from active duty to veteran status as smooth as possible. And we will not rest until every seriously injured service member returning from combat receives the quality treatment they need in a compassionate and timely way.

In that regard, Mr. Chairman, I have recently directed the hiring of 100 new patient advocates to serve as the voices for our severely wounded soldiers, as they transition from DOD hospitals, to our VA system, to their lives as civilians.

In response to Walter Reed, on March 6 the President issued an Executive order forming a Presidential commission, led by Senator Dole and Secretary Shalala, tasked to review the care provided to our wounded servicemen and women. Their work is ongoing. In addition, President Bush appointed me, in that same Executive order, to Chair an inter-Cabinet taskforce that will report to the President on Federal services for our returning troops.

The taskforce is examining services that are currently provided, as well as existing gaps in those services. It is seeking recommendations from Federal departments on ways to fill those gaps as quickly as possible. This taskforce will report to the President on April 19.

Let me speak of veterans' benefits. The VA's primary focus within the administration of benefits remains unchanged, delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging, but we will succeed. The volume of claims applications has grown substantially during the past few years, and is now the highest it's been in 15 years. We received more than 806,000 claims last year. Our pending inventory of disability rating claims is currently about 400,000 claims, and averages a processing time of 177 days. And this is too long.

We must and will reduce the pending inventory and shorten the time veterans must wait for decisions on their claims. Through a combination of aggressive management and productivity improvements and our 2008 request we will add 450 additional staff and continue to improve our performance, while maintaining high quality. With this budget, we project that we will reduce our claims processing time by 18 percent, while maintaining high quality. Further, we continue to prioritize the claims processing for those claims of our OIF/OEF combatant veterans.

For the National Cemetery Administration, we expect to perform nearly 105,000 interments, in 2008. And, this is primarily the result of the aging of the World War II and Korean War veteran population. We are experiencing the biggest expansion of the National Cemetery System since the Civil War, including six new cemeteries in this, President Bush's 2008 budget. Every day now, more than 1,800 veterans die. Most of them are World War II and Korean War veterans.

Let me mention capital programs. The VA's 2008 request includes \$1.1 billion in new budget authority for our capital programs. Our request includes \$727 million for major construction projects, \$233 million for minor construction, \$85 million in grants for State extended-care facilities, and \$32 million in grants to build State veterans' cemeteries. The 2008 request for construction funding for our healthcare programs is \$750 million. These resources will be devoted to the continuation of the Capital Asset for Realignment for Enhanced Services, or CARES program.

Over the last 5 years, \$3.7 billion in total funding has been provided for CARES. With our request for major construction are the resources to continue six medical facility projects already underway. They are in Pittsburgh, Denver, Las Vegas, Orlando, Lee County, Florida, and Syracuse, New York. Funds are also included for six new national cemeteries in Bakersfield, California, Birmingham, Alabama, Columbia-Greenville, South Carolina, Jacksonville, Florida, Southeastern Pennsylvania, and Sarasota County, Florida.

Information technology--the VA's 2008 budget request for IT is \$1.86 billion, which includes the first phase of our reorganization of IT functions in the Department. This major transformation of IT will bring our program in line with the best practices in the IT industry. Greater centralization will play a significant role in ensuring that we fulfill our promise to make the VA the gold-standard for data security within the Federal Government, just as we have done with electronic medical records.

And speaking of electronic medical records, the most critical IT project for our medical care program, is the continued operation and improvement of the Department's electronic health records. Electronic health records are a Presidential priority and VA's electronic health record system has been recognized nationally as the model for increasing productivity, quality, and patient safety.

And, I would like to point out--and I take great pride in doing so--the, an article of Monday's Washington Post in the Health section saying, ``The VA takes the lead in paperless care.'' And, it takes up almost the entire section, extolling

the VA healthcare and the VA electronic medical records. And, it makes me very proud of the people who work for the VA and who have achieved that.

We will continue to lead the way with electronic health records and we want to work closely with the Department of Defense and other Federal agencies to make the electronic sharing of medical information universally a reality, sooner rather than later.

Mr. Chairman, I also want to take this opportunity to inform you that I have formed a special Advisory Committee on OIF/OEF veterans and their families. Under its charter, the committee will focus on advising me, directly, to ensure that all men and women with active military service in Iraq and Afghanistan are transitioned to the VA in a, in a hassle-free, informed manner. The committee will pay particular attention to severely disabled veterans and their families.

Yesterday I was in Las Vegas speaking at a VA-DOD conference of 1,400 people focused on improving healthcare to transitioning combat veterans. In recent months, as I've traveled across the country, I have met with the leadership of the Southern, Central, and Northern Commands to talk to them about how the VA and the DOD could work better together to care for our soldiers, sailors, airmen, Marines, and Coast Guardsmen who are returning from the global war on terror.

PREPARED STATEMENT

I've also met with the Commandant of the Marine Corps, the Chiefs of the Reserve Components and the Senior Enlisted Advisors of the Active and Reserve components, including the Coast Guard, for that same reason.

We at the VA recognize and take very seriously our noble mission of serving those who have served us. This budget of the President's will allow us to fulfill our responsibilities.

Thank you, Mr. Chairman.

[The statement follows:]

Prepared Statement of R. James Nicholson

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2008 budget proposal for the Department of Veterans Affairs (VA). The request totals \$86.75 billion--\$44.98 billion for entitlement programs and \$41.77 billion for discretionary programs. The total request is \$37.80 billion, or 77 percent, above the funding level in effect when the President took office.

The President's requested funding level will allow VA to continue to improve the delivery of benefits and services to veterans and their families in three primary areas that are critical to the achievement of our mission:

- to provide timely, high-quality healthcare to a growing number of patients who count on VA the most--veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;
- to improve the delivery of benefits through the timeliness and accuracy of claims processing; and

--to increase veterans' access to a burial option in a national or state veterans' cemetery.
ensuring a seamless transition from active military service to civilian life

The President's 2008 budget request provides the resources necessary to ensure that service members' transition from active duty military status to civilian life continues to be as smooth and seamless as possible. We will continue to ensure that every seriously injured or ill serviceman or woman returning from combat in Operation Iraqi Freedom and Operation Enduring Freedom receives the treatment they need in a timely way.

Recently I announced plans to create a special Advisory Committee on Operation Iraqi Freedom/Operation Enduring Freedom Veterans and Families. The panel, with membership including veterans, spouses, and parents of the latest generation of combat veterans, will report directly to me. Under its charter, the committee will focus on the concerns of all men and women with active military service in Operation Iraqi Freedom or Operation Enduring Freedom, but will pay particular attention to severely disabled veterans and their families.

We will expand our ``Coming Home to Work'' initiative to help disabled service members more easily make the transition from military service to civilian life. This is a comprehensive intergovernmental and public-private alliance that will provide separating service members from Operation Iraqi Freedom and Operation Enduring Freedom with employment opportunities when they return home from their military service. This project focuses on making sure service members have access to existing resources through local and regional job markets, regardless of where they separate from their military service, where they return, or the career or education they pursue.

VA launched an ambitious outreach initiative to ensure separating combat veterans know about the benefits and services available to them. During 2006 VA conducted over 8,500 briefings attended by more than 393,000 separating service members and returning reservists and National Guard members. The number of attendees was 20 percent higher in 2006 than it was in 2005 attesting to our improved outreach effort.

Additional pamphlet mailings following separation and briefings conducted at town hall meetings are sources of important information for returning National Guard members and reservists. VA has made a special effort to work with National Guard and reserve units to reach transitioning service members at demobilization sites and has trained recently discharged veterans to serve as National Guard Bureau liaisons in every state to assist their fellow combat veterans.

Each VA medical center and regional office has a designated point of contact to coordinate activities locally and to ensure the healthcare and benefits needs of returning service members and veterans are fully met. VA has distributed specific guidance to field staff to make sure the roles and functions of the points of contact and case managers are fully understood and that proper coordination of benefits and services occurs at the local level.

For combat veterans returning from Iraq and Afghanistan, their contact with VA often begins with priority scheduling for healthcare, and for the most seriously wounded, VA counselors visit their bedside in military wards before separation to assist them with their disability claims and ensure timely compensation payments when they leave active duty.

In an effort to assist wounded military members and their families, VA has placed workers at key military hospitals where severely injured

service members from Iraq and Afghanistan are frequently sent for care. These include benefit counselors who help service members obtain VA services as well as social workers who facilitate healthcare coordination and discharge planning as service members transition from military to VA healthcare. Under this program, VA staff provide assistance at 10 military treatment facilities around the country, including Walter Reed Army Medical Center, National Naval Medical Center Bethesda, Naval Medical Center San Diego, and Womack Army Medical Center at Fort Bragg.

To better meet the healthcare needs of the newest generation of combat veterans returning from Iraq and Afghanistan, VA has established a polytrauma system of care for veterans and active duty personnel with lasting disabilities due to polytrauma and traumatic brain injury. This system of care will provide the highest quality of medical, rehabilitation, and support services. This initiative was developed consistent with three fundamental principles--(1) geographic distribution of specialty rehabilitation programs so as to facilitate transitioning veterans into their home communities; (2) use of an interdisciplinary model of care delivery where specialists from several medical and rehabilitation disciplines work together to develop an integrated treatment plan for each veteran; and (3) provide lifelong services for veterans with severe impairments and functional disabilities resulting from polytrauma and traumatic brain injury.

VA has expanded its four polytrauma centers in Minneapolis, Palo Alto, Richmond, and Tampa to encompass additional specialties to treat patients for multiple complex injuries. Our efforts are being expanded to 21 polytrauma network sites and clinic support teams around the country providing state-of-the-art treatment closer to injured veterans' homes. We have made training mandatory for all physicians and other key healthcare personnel on the most current approaches and treatment protocols for effective care of patients with traumatic brain injuries. At each of our medical centers, we will screen all recent combat veterans for traumatic brain injury. We have also created an outside panel of experts to review VA's complete polytrauma system of care, including programs focused specifically on patients with traumatic brain injuries. Furthermore, we established a polytrauma call center in February 2006 to assist the families of our most seriously injured combat veterans and service members. This call center operates 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members.

VA is improving coordination of care for veterans with polytrauma and traumatic brain injury by assigning a social work case manager to every patient treated at the polytrauma centers. These case managers handle the continuum of care and care coordination, act as the point of contact for emerging medical, psychosocial, or rehabilitation problems, and provide psychosocial support and education. In addition, we are using state-of-the-art video conferencing that permits top specialists to take an active role in the treatment of patients in remote locations.

VA has significantly expanded its counseling and other medical care services for recently discharged veterans suffering from mental health disorders, including post-traumatic stress disorder. We have launched new programs, including dozens of new mental health teams based in VA medical facilities focused on early identification and management of stress-related disorders, as well as the recruitment of about 100 combat veterans as counselors to provide briefings to transitioning service members regarding military-related readjustment needs.

medical care

We are requesting \$36.6 billion for medical care in 2008, a total more than 83 percent higher than the funding available at the beginning of the Bush Administration. Our total medical care request is comprised of funding for medical services (\$27.2 billion), medical administration (\$3.4 billion), medical facilities (\$3.6 billion), and resources from medical care collections (\$2.4 billion).

Legislative Proposals

The President's 2008 budget request identifies three legislative proposals which ask veterans with comparatively greater means and no compensable service-connected disabilities to assume a small share of the cost of their healthcare.

The first proposal would assess Priority 7 and 8 veterans with an annual enrollment fee based on their family income:

Family income	Annual enrollment fee
Under \$50,000.....	(\1\)
\$50,000-\$74,999.....	\$250
\$75,000-\$99,999.....	500
\$100,000 and above.....	750

\1\ None.

The second legislative proposal would increase the pharmacy co-payment for Priority 7 and 8 veterans from \$8 to \$15 for a 30-day supply of drugs. And the last provision would eliminate the practice of offsetting or reducing VA first-party co-payment debts with collection recoveries from third-party health plans.

While our budget requests in recent years have included legislative proposals similar to these, the provisions identified in the President's 2008 budget are markedly different in that they have no impact on the resources we are requesting for VA medical care. Our budget request includes the total funding needed for the Department to continue to provide veterans with timely, high-quality medical services that set the national standard of excellence in the healthcare industry. Unlike previous budgets, these legislative proposals do not reduce our discretionary medical care appropriations. Instead, these three provisions, if enacted, would generate an estimated \$2.3 billion in mandatory receipts to the Treasury from 2008 through 2012.

Workload

During 2008, we expect to treat about 5,819,000 patients. This total is more than 134,000 (or 2.4 percent) above the 2007 estimate. Patients in Priorities 1-6--veterans with service-connected conditions, lower incomes, special healthcare needs, and service in Iraq or Afghanistan--will comprise 68 percent of the total patient population in 2008, but they will account for 85 percent of our healthcare costs. The number of patients in Priorities 1-6 will grow by 3.3 percent from 2007 to 2008.

We expect to treat about 263,000 veterans in 2008 who served in Operation Iraqi Freedom and Operation Enduring Freedom. This is an increase of 54,000 (or 26 percent) above the number of veterans from these two campaigns that we anticipate will come to VA for healthcare in 2007, and 108,000 (or 70 percent) more than the number we treated in 2006.

Funding Drivers

Our 2008 request for \$36.6 billion in support of our medical care program was largely determined by three key cost drivers in the actuarial model we use to project veteran enrollment in VA's healthcare system as well as the utilization of healthcare services of those enrolled: inflation; trends in the overall healthcare industry; and trends in VA healthcare.

The impact of the composite rate of inflation of 4.45 percent within the actuarial model will increase our resource requirements for acute inpatient and outpatient care by nearly \$2.1 billion. This includes the effect of additional funds (\$690 million) needed to meet higher payroll costs as well as the influence of growing costs (\$1.4 billion) for supplies, as measured in part by the Medical Consumer Price Index. However, inflationary trends have slowed during the last year.

There are several trends in the U.S. healthcare industry that continue to increase the cost of providing medical services. These trends expand VA's cost of doing business regardless of any changes in enrollment, number of patients treated, or program initiatives. The two most significant trends are the rising utilization and intensity of healthcare services. In general, patients are using medical care services more frequently and the intensity of the services they receive continues to grow. For example, sophisticated diagnostic tests, such as magnetic resonance imaging (MRI), are now more frequently used either in place of, or in addition to, less costly diagnostic tools such as x-rays. As another illustration, advances in cancer screening technologies have led to earlier diagnosis and prolonged treatment which may include increased use of costly pharmaceuticals to combat this disease. These types of medical services have resulted in improved patient outcomes and higher quality healthcare. However, they have also increased the cost of providing care.

The cost of providing timely, high-quality healthcare to our Nation's veterans is also growing as a result of several factors that are unique to VA's healthcare system. We expect to see changes in the demographic characteristics of our patient population. Our patients as a group will be older, will seek care for more complex medical conditions, and will be more heavily concentrated in the higher cost priority groups. Furthermore, veterans are submitting disability compensation claims for an increasing number of medical conditions, which are also increasing in complexity. This results in the need for disability compensation medical examinations, the majority of which are conducted by our Veterans Health Administration, that are more complex, costly, and time consuming. These projected changes in the case mix of our patient population and the growing complexity of our disability claims process will result in greater resource needs.

Quality of Care

The resources we are requesting for VA's medical care program will allow us to strengthen our position as the Nation's leader in providing high-quality healthcare. VA has received numerous accolades from external organizations documenting the Department's leadership position in providing world-class healthcare to veterans. For example, our record of success in healthcare delivery is substantiated by the results of the 2006 American Customer Satisfaction Index (ACSI) survey. Conducted by the National Quality Research Center at the University of Michigan Business School, the ACSI survey found that customer satisfaction with VA's healthcare system increased last year and was higher than the private sector for the seventh consecutive year. The

data revealed that inpatients at VA medical centers recorded a satisfaction level of 84 out of a possible 100 points, or 10 points higher than the rating for inpatient care provided by the private-sector healthcare industry. VA's rating of 82 for outpatient care was 8 points better than the private sector.

Citing VA's leadership role in transforming healthcare in America, Harvard University recognized the Department's computerized patient records system by awarding VA the prestigious ``Innovations in American Government Award'' in 2006. Our electronic health records have been an important element in making VA healthcare the benchmark for 294 measures of disease prevention and treatment in the United States. The value of this system was clearly demonstrated when every patient medical record from the areas devastated by Hurricane Katrina was made available to all VA healthcare providers throughout the Nation within 100 hours of the time the storm made landfall. Veterans were able to quickly resume their treatments, refill their prescriptions, and get the care they needed because of the electronic health records system--a real, functioning health information exchange that has been a proven success resulting in improved quality of care. It can serve as a model for the healthcare industry as the Nation moves forward with the public/private effort to develop a National Health Information Network.

The Department also received an award from the American Council for Technology for our collaboration with the Department of Defense on the Bidirectional Health Information Exchange program. This innovation permits the secure, real-time exchange of medical record data between the two departments, thereby avoiding duplicate testing and surgical procedures. It is an important step forward in making the transition from active duty to civilian life as smooth and seamless as possible.

In its July 17, 2006, edition, Business Week featured an article about VA healthcare titled ``The Best Medical Care in the United States.'' This article outlines many of the Department's accomplishments that have helped us achieve our position as the leading provider of healthcare in the country, such as higher quality of care than the private sector, our nearly perfect rate of prescription accuracy, and the most advanced computerized medical records system in the Nation. Similar high praise for VA's healthcare system was documented in the September 4, 2006, edition of Time Magazine in an article titled ``How VA Hospitals Became the Best.'' In addition, a study conducted by Harvard Medical School concluded that Federal hospitals, including those managed by VA, provide the best care available for some of the most common life-threatening illnesses such as congestive heart failure, heart attack, and pneumonia. Their research results were published in the December 11, 2006, edition of the Annals of Internal Medicine.

These external acknowledgments of the superior quality of VA healthcare reinforce the Department's own findings. We use two primary measures of healthcare quality--clinical practice guidelines index and prevention index. These measures focus on the degree to which VA follows nationally recognized guidelines and standards of care that the medical literature has proven to be directly linked to improved health outcomes for patients. Our performance on the clinical practice guidelines index, which focuses on high-prevalence and high-risk diseases that have a significant impact on veterans' overall health status, is expected to grow to 85 percent in 2008, or a 1 percentage point rise over the level we expect to achieve this year. As an indicator aimed at primary prevention and early detection recommendations dealing with immunizations and screenings, the

prevention index will be maintained at our existing high level of performance of 88 percent.

Access to Care

With the resources requested for medical care in 2008, the Department will be able to continue our exceptional performance dealing with access to healthcare--96 percent of primary care appointments will be scheduled within 30 days of patients' desired date, and 95 percent of specialty care appointments will be scheduled within 30 days of patients' desired date. We will minimize the number of new enrollees waiting for their first appointment. We reduced this number by 94 percent from May 2006 to January 2007, to a little more than 1,400, and we will continue to place strong emphasis on lowering, and then holding, the waiting list to as low a level as possible.

An important component of our overall strategy to improve access and timeliness of service is the implementation on a national scale of Advanced Clinic Access, an initiative that promotes the efficient flow of patients by predicting and anticipating patient needs at the time of their appointment. This involves assuring that specific medical equipment is available, arranging for tests that should be completed either prior to, or at the time of, the patient's visit, and ensuring all necessary health information is available. This program optimizes clinical scheduling so that each appointment or inpatient service is most productive. In addition, this reduces unnecessary appointments, allowing for relatively greater workload and increased patient-directed scheduling.

Funding for Major Healthcare Programs and Initiatives

Our request includes \$4.6 billion for extended care services, 90 percent of which will be devoted to institutional long-term care and 10 percent to non-institutional care. By continuing to enhance veterans' access to non-institutional long-term care, the Department can provide extended care services to veterans in a more clinically appropriate setting, closer to where they live, and in the comfort and familiar settings of their homes surrounded by their families. This includes adult day healthcare, home-based primary care, purchased skilled home healthcare, homemaker/home health aide services, home respite and hospice care, and community residential care. During 2008 we will increase the number of patients receiving non-institutional long-term care, as measured by the average daily census, to over 44,000. This represents a 19.1 percent increase above the level we expect to reach in 2007 and a 50.3 percent rise over the 2006 average daily census.

The President's request includes nearly \$3 billion to continue our effort to improve access to mental health services across the country. These funds will help ensure VA provides standardized and equitable access throughout the Nation to a full continuum of care for veterans with mental health disorders. The resources will support both inpatient and outpatient psychiatric treatment programs as well as psychiatric residential rehabilitation treatment services. We estimate that about 80 percent of the funding for mental health will be for the treatment of seriously mentally ill veterans, including those suffering from post-traumatic stress disorder (PTSD). An example of our firm commitment to provide the best treatment available to help veterans recover from these mental health conditions is our ongoing outreach to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, as well as increased readjustment and PTSD services.

In 2008 we are requesting \$752 million to meet the needs of the 263,000 veterans with service in Operation Iraqi Freedom and Operation Enduring Freedom whom we expect will come to VA for medical care.

Veterans with service in Iraq and Afghanistan continue to account for a rising proportion of our total veteran patient population. In 2008 they will comprise 5 percent of all veterans receiving VA healthcare compared to the 2006 figure of 3.1 percent. Veterans deployed to combat zones are entitled to 2 years of eligibility for VA healthcare services following their separation from active duty even if they are not otherwise immediately eligible to enroll for our medical services.

Medical Collections

The Department expects to receive nearly \$2.4 billion from medical collections in 2008, which is \$154 million, or 7.0 percent, above our projected collections for 2007. As a result of increased workload and process improvements in 2008, we will collect an additional \$82 million from third-party insurance payers and an extra \$72 million resulting from increased pharmacy workload.

We have several initiatives underway to strengthen our collections processes:

- The Department has established a private-sector based business model pilot tailored for our revenue operations to increase collections and improve our operational performance. The pilot Consolidated Patient Account Center (CPAC) is addressing all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes. The CPAC currently serves revenue operations for medical centers and clinics in one of our Veterans Integrated Service Networks but this program will be expanded to serve other networks.
- VA continues to work with the Centers for Medicare and Medicaid Services contractors to provide a Medicare-equivalent remittance advice for veterans who are covered by Medicare and are using VA healthcare services. We are working to include additional types of claims that will result in more accurate payments and better accounting for receivables through use of more reliable data for claims adjudication.
- We are conducting a phased implementation of electronic, real-time outpatient pharmacy claims processing to facilitate faster receipt of pharmacy payments from insurers.
- The Department has initiated a campaign that has resulted in an increasing number of payers now accepting electronic coordination of benefits claims. This is a major advancement toward a fully integrated, interoperable electronic claims process.

medical research

The President's 2008 budget includes \$411 million to support VA's medical and prosthetic research program. This amount will fund nearly 2,100 high-priority research projects to expand knowledge in areas critical to veterans' healthcare needs, most notably research in the areas of mental illness (\$49 million), aging (\$42 million), health services delivery improvement (\$36 million), cancer (\$35 million), and heart disease (\$31 million).

VA's medical research program has a long track record of success in conducting research projects that lead to clinically useful interventions that improve the health and quality of life for veterans as well as the general population. Recent examples of VA research results that are now being applied to clinical care include the discovery that vaccination against varicella-zoster (the same virus that causes chickenpox) decreases the incidence and/or severity of shingles, development of a system that decodes brain waves and

translates them into computer commands that allow quadriplegics to perform simple tasks like turning on lights and opening e-mail using only their minds, improvements in the treatment of post-traumatic stress disorder that significantly reduce trauma nightmares and other sleep disturbances, and discovery of a drug that significantly improves mental abilities and behavior of certain schizophrenics.

In addition to VA appropriations, the Department's researchers compete for and receive funds from other Federal and non-Federal sources. Funding from external sources is expected to continue to increase in 2008. Through a combination of VA resources and funds from outside sources, the total research budget in 2008 will be almost \$1.4 billion.

general operating expenses

The Department's 2008 resource request for General Operating Expenses (GOE) is \$1.472 billion. This is \$617 million, or 72.2 percent, above the funding level in place when the President took office. Within this total GOE funding request, \$1.198 billion is for the administration of non-medical benefits by the Veterans Benefits Administration (VBA) and \$274 million will be used to support General Administration activities.

Compensation and Pensions Workload and Performance Management

VA's primary focus within the administration of non-medical benefits remains unchanged--delivering timely and accurate benefits to veterans and their families. Improving the delivery of compensation and pension benefits has become increasingly challenging during the last few years due to a steady and sizeable increase in workload. The volume of claims applications has grown substantially during the last few years and is now the highest it has been in the last 15 years. The number of claims we received was more than 806,000 in 2006. We expect this high volume of claims filed to continue, as we are projecting the receipt of about 800,000 claims a year in both 2007 and 2008.

The number of active duty service members as well as reservists and National Guard members who have been called to active duty to support Operation Enduring Freedom and Operation Iraqi Freedom is one of the key drivers of new claims activity. This has contributed to an increase in the number of new claims, and we expect this pattern to persist. An additional reason that the number of compensation and pension claims is climbing is the Department's commitment to increase outreach. We have an obligation to extend our reach as far as possible and to spread the word to veterans about the benefits and services VA stands ready to provide.

Disability compensation claims from veterans who have previously filed a claim comprise about 55 percent of the disability claims received by the Department each year. Many veterans now receiving compensation suffer from chronic and progressive conditions, such as diabetes, mental illness, and cardiovascular disease. As these veterans age and their conditions worsen, we experience additional claims for increased benefits.

The growing complexity of the claims being filed also contributes to our workload challenges. For example, the number of original compensation cases with eight or more disabilities claimed nearly doubled during the last 4 years, reaching more than 51,000 claims in 2006. Almost one in every four original compensation claims received last year contained eight or more disability issues. In addition, we expect to continue to receive a growing number of complex disability claims resulting from PTSD, environmental and infectious risks, traumatic brain injuries, complex combat-related injuries, and

complications resulting from diabetes. Each claim now takes more time and more resources to adjudicate. Additionally, as VA receives and adjudicates more claims, this results in a larger number of appeals from veterans and survivors, which also increases workload in other parts of the Department, including the Board of Veterans' Appeals.

The Veterans Claims Assistance Act of 2000 has significantly increased both the length and complexity of claims development. VA's notification and development duties have grown, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Also, we are now required to review the claims at more points in the adjudication process.

We will address our ever-growing workload challenges in several ways. First, we will continue to improve our productivity as measured by the number of claims processed per staff member, from 98 in 2006 to 101 in 2008. Second, we will continue to move work among regional offices in order to maximize our resources and enhance our performance. Third, we will further advance staff training and other efforts to improve the consistency and quality of claims processing across regional offices. And fourth, we will ensure our claims processing staff has easy access to the manuals and other reference material they need to process claims as efficiently and effectively as possible and further simplify and clarify benefit regulations.

Through a combination of management/productivity improvements and an increase in resources in 2008 to support 457 additional staff above the 2007 level, we will improve our performance in the area most critical to veterans--the timeliness of processing rating-related compensation and pension claims. We expect to improve the timeliness of processing these claims to 145 days in 2008. This level of performance is 15 days better than our projected timeliness for 2007 and a 32-day improvement from the average processing time we achieved last year. In addition, we anticipate that our pending inventory of disability claims will fall to about 330,000 by the end of 2008, a reduction of more than 40,000 (or 10.9 percent) from the level we project for the end of 2007, and nearly 49,000 (or 12.9 percent) lower than the inventory at the close of 2006. At the same time we are improving timeliness, we will also increase the accuracy of our decisions on claims from 88 percent in 2006 to 90 percent in 2008.

Education and Vocational Rehabilitation and Employment Performance

With the resources we are requesting in 2008, key program performance will improve in both the education and vocational rehabilitation and employment programs. The timeliness of processing original education claims will improve by 15 days during the next 2 years, falling from 40 days in 2006 to 25 days in 2008. During this period, the average time it takes to process supplemental claims will improve from 20 days to just 12 days. These performance improvements will be achieved despite an increase in workload. The number of education claims we expect to receive will reach about 1,432,000 in 2008, or 4.8 percent higher than last year. In addition, the rehabilitation rate for the vocational rehabilitation and employment program will climb to 75 percent in 2008, a gain of 2 percentage points over the 2006 performance level. The number of program participants will rise to about 94,500 in 2008, or 5.3 percent higher than the number of participants in 2006.

Our 2008 request includes \$6.3 million for a Contact Management Support Center for our education program. These funds will be used during peak enrollment periods for contract customer service representatives who will handle all education calls placed through our

toll-free telephone line. We currently receive about 2.5 million phone inquiries per year. This initiative will allow us to significantly improve performance for both the blocked call rate and the abandoned call rate.

The 2008 resource request for VBA includes about \$4.3 million to enhance our educational and vocational counseling provided to disabled service members through the Disabled Transition Assistance Program. Funds for this initiative will ensure that briefings are conducted by experts in the field of vocational rehabilitation, including contracting for these services in localities where VA professional staff are not available. The contractors would be trained by VA staff to ensure consistent, quality information is provided. Also in support of the vocational rehabilitation and employment program, we are seeking \$1.5 million as part of an ongoing project to retire over 650,000 counseling, evaluation, and rehabilitation folders stored in regional offices throughout the country. All of these folders pertain to cases that have been inactive for at least 3 years and retention of these files poses major space problems.

In addition, our 2008 request includes \$2.4 million to continue a major effort to centralize finance functions throughout VBA, an initiative that will positively impact operations for all of our benefits programs. The funds to support this effort will be used to begin the consolidation and centralization of voucher audit, agent cashier, purchase card, and payroll operations currently performed by all regional offices.

national cemetery administration

The President's 2008 budget request includes \$166.8 million in operations and maintenance funding for the National Cemetery Administration (NCA). These resources will allow us to meet the growing workload at existing cemeteries by increasing staffing and funding for contract maintenance, supplies, and equipment. We expect to perform nearly 105,000 interments in 2008, or 8.4 percent higher than the number of interments we performed in 2006. The number of developed acres (over 7,800) that must be maintained in 2008 will be 7.3 percent greater than last year.

Our budget request includes \$3.7 million to prepare for the activation of interment operations at six new national cemeteries--Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; southeastern Pennsylvania; and Sarasota County, Florida. Establishment of these six new national cemeteries is directed by the National Cemetery Expansion Act of 2003.

The 2008 budget has \$9.1 million to address gravesite renovations as well as headstone and marker realignment. These improvements in the appearance of our national cemeteries will help us maintain the cemeteries as shrines dedicated to preserving our Nation's history and honoring veterans' service and sacrifice.

With the resources requested to support NCA activities, we will expand access to our burial program by increasing the percent of veterans served by a burial option within 75 miles of their residence to 84.6 percent in 2008, which is 4.4 percentage points above our performance level at the close of 2006. In addition, we will continue to increase the percent of respondents who rate the quality of service provided by national cemeteries as excellent to 98 percent in 2008, or 4 percentage points higher than the level of performance we reached last year.

capital programs (construction and grants to states)

VA's 2008 request includes \$1.078 billion in appropriated funding

for our capital programs. Our request includes \$727.4 million for major construction projects, \$233.4 million for minor construction, \$85 million in grants for the construction of State extended care facilities, and \$32 million in grants for the construction of State veterans cemeteries.

The 2008 request for construction funding for our healthcare programs is \$750 million--\$570 million for major construction and \$180 million for minor construction. All of these resources will be devoted to continuation of the Capital Asset Realignment for Enhanced Services (CARES) program, total funding for which comes to \$3.7 billion over the last 5 years. CARES will renovate and modernize VA's healthcare infrastructure, provide greater access to high-quality care for more veterans, closer to where they live, and help resolve patient safety issues. Within our request for major construction are resources to continue six medical facility projects already underway:

- Denver, Colorado (\$61.3 million)--parking structure and energy development for this replacement hospital
- Las Vegas, Nevada (\$341.4 million)--complete construction of the hospital, nursing home, and outpatient facilities
- Lee County, Florida (\$9.9 million)--design of an outpatient clinic (land acquisition is complete)
- Orlando, Florida (\$35.0 million)--land acquisition for this replacement hospital
- Pittsburgh, Pennsylvania (\$40.0 million)--continue consolidation of a 3-division to a 2-division hospital
- Syracuse, New York (\$23.8 million)--complete construction of a spinal cord injury center.

Minor construction is an integral component of our overall capital program. In support of the medical care and medical research programs, minor construction funds permit VA to address space and functional changes to efficiently shift treatment of patients from hospital-based to outpatient care settings; realign critical services; improve management of space, including vacant and underutilized space; improve facility conditions; and undertake other actions critical to CARES implementation. Our 2008 request for minor construction funds for medical care and research will provide the resources necessary for us to address critical needs in improving access to healthcare, enhancing patient privacy, strengthening patient safety, enhancing research capability, correcting seismic deficiencies, facilitating realignments, increasing capacity for dental services, and improving treatment in special emphasis programs.

We are requesting \$191.8 million in construction funding to support the Department's burial program--\$167.4 million for major construction and \$24.4 million for minor construction. Within the funding we are requesting for major construction are resources to establish six new cemeteries mandated by the National Cemetery Expansion Act of 2003. As previously mentioned, these will be in Bakersfield (\$19.5 million), Birmingham (\$18.5 million), Columbia-Greenville (\$19.2 million), Jacksonville (\$22.4 million), Sarasota (\$27.8 million), and southeastern Pennsylvania (\$29.6 million). The major construction request in support of our burial program also includes \$29.4 million for a gravesite development project at Fort Sam Houston National Cemetery.

information technology

VA's 2008 budget request for information technology (IT) is \$1.859 billion. This budget reflects the first phase of our reorganization of IT functions in the Department which will establish a new IT management

structure in VA. The total funding for IT in 2008 includes \$555 million for more than 5,500 staff who have been moved to support operations and maintenance activities. Prior to 2008, the funding and staff supporting these IT activities were reflected in other accounts throughout the Department.

Later in 2007 we will implement the second phase of our IT reorganization strategy by moving funding and staff devoted to development projects and activities. As a result of the second stage of the IT reorganization, the Chief Information Officer will be responsible for all operations and maintenance as well as development activities, including oversight of, and accountability for, all IT resources within VA. This reorganization will make the most efficient use of our IT resources while improving operational effectiveness, providing standardization, and eliminating duplication.

This major transformation of IT will bring our program under more centralized control and will play a significant role in ensuring we fulfill my promise to make VA the gold standard for data security within the Federal government. We have taken very aggressive steps during the last several months to ensure the safety of veterans' personal information, including training and educating our employees on the critical responsibility they have to protect personal and health information, launching an initiative to expeditiously upgrade all VA computers with enhanced data security and encryption, entering into an agreement with an outside firm to provide free data breach analysis services, initiating any needed background investigations of employees to ensure consistency with their level of authority and responsibilities in the Department, and beginning a campaign at all of our healthcare facilities to replace old veteran identification cards with new cards that reduce veterans' vulnerability to identify theft. These steps are part of our broader commitment to improve our IT and cyber security policies and procedures.

Within our total IT request of \$1.859 billion, \$1.304 billion (70 percent) will be for non-payroll costs and \$555 million (30 percent) will be for payroll costs. Of the non-payroll funding, \$461 million will support projects for our medical care and medical research programs, \$66 million will be devoted to projects for our benefits programs, and \$446 million will be needed for IT infrastructure projects. The remaining \$331 million of our non-payroll IT resources in 2008 will fund centrally-managed projects, such as VA's cyber security program, as well as management projects that support department-wide initiatives and operations like the replacement of our aging financial management system and the development and implementation of a new human resources management system.

The most critical IT project for our medical care program is the continued operation and improvement of the Department's electronic health record system, a Presidential priority which has been recognized nationally for increasing productivity, quality, and patient safety. Within this overall initiative, we are requesting \$131.9 million for ongoing development and implementation of HealtheVet-VistA (Veterans Health Information Systems and Technology Architecture). This initiative will incorporate new technology, new or reengineered applications, and data standardization to improve the sharing of, and access to, health information, which in turn, will improve the status of veterans' health through more informed clinical care. This system will make use of standards accepted by the Secretary of Health and Human Services that will enhance the sharing of data within VA as well as with other Federal agencies and public and private sector

organizations. Health data will be stored in a veteran-centric format replacing the current facility-centric system. The standardized health information can be easily shared between facilities, making patients' electronic health records available to them and to all those authorized to provide care to veterans.

Until HealtheVet-VistA is operational, we need to maintain the VistA legacy system. This system will remain operational as new applications are developed and implemented. This approach will mitigate transition and migration risks associated with the move to the new architecture. Our budget provides \$129.4 million in 2008 for the VistA legacy system. Funding for the legacy system will decline as we advance our development and implementation of HealtheVet-VistA.

In veterans benefits programs, we are requesting \$31.7 million in 2008 to support our IT systems that ensure compensation and pension claims are properly processed and tracked, and that payments to veterans and eligible family members are made on a timely basis. Our 2008 request includes \$3.5 million to continue the development of The Education Expert System. This will replace the existing benefit payment system with one that will, when fully deployed, receive application and enrollment information and process that information electronically, reducing the need for human intervention.

VA is requesting \$446 million in 2008 for IT infrastructure projects to support our healthcare, benefits, and burial programs through implementation and ongoing management of a wide array of technical and administrative support systems. Our request for resources in 2008 will support investment in five infrastructure projects now centrally managed by the CIO--computing infrastructure and operations (\$181.8 million); network infrastructure and operations (\$31.7 million); voice infrastructure and operations (\$71.9 million); data and video infrastructure and operations (\$130.8 million); and regional data centers (\$30.0 million).

VA's 2008 request provides \$70.1 million for cyber security. This ongoing initiative involves the development, deployment, and maintenance of a set of enterprise-wide controls to better secure our IT architecture in support of all of the Department's program operations. Our request also includes \$35.0 million for the Financial and Logistics Integrated Technology Enterprise (FLITE) system. FLITE is being developed to address a long-standing material weakness and will effectively integrate and standardize financial and logistics data and processes across all VA offices as well as provide management with access to timely and accurate financial, logistics, budget, asset, and related information on VA-wide operations. In addition, we are asking for \$34.1 million for a new state-of-the-art human resource management system that will result in an electronic employee record and the capability to produce critical management information in a fraction of the time it now takes using our antiquated paper-based system.

summary

Our 2008 budget request of \$86.75 billion will provide the resources necessary for VA to:

- strengthen our position as the Nation's leader in providing high-quality healthcare to a growing patient population, with an emphasis on those who count on us the most--veterans returning from service in Operation Iraqi Freedom and Operation Enduring Freedom, veterans with service-connected disabilities, those with lower incomes, and veterans with special healthcare needs;
- improve the delivery of benefits through the timeliness and accuracy of claims processing; and

--increase veterans' access to a burial option by opening new national and State veterans' cemeteries.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world.

Senator Reed. Thank you very much, Mr. Secretary, for your statement.

We will engage in our 6-minute rounds of questioning. And, I will yield my initial 6 minutes to Senator Byrd.

Senator Byrd, do you have questions?

Senator Byrd. Mr. Secretary we have been told that the VA hospitals are juggling the books to make it appear that the time to get an appointment is shorter than it is. Allegedly, appointments are being made, then cancelled, and rescheduled to make it appear that the time from making the appointment, to actually seeing a doctor, is shorter than it is. Are you aware of this practice?

Secretary Nicholson. Senator Byrd, I've been Secretary now, for about 26 months and in that time, I have had it brought to my attention that this might be happening in isolated cases. And, I'm also told that the Inspector General looked into this. Because this would be a very unacceptable practice, and that it may have been found in very isolated cases, but it certainly is not systemic.

I'm going to read this, because I'm under oath so I want to be as precise as I can be. First of all, I can tell you that the VA is very committed to improving access. All veterans who have urgent or emergent needs that come to a hospital are seen immediately. We are focused on getting appointments within 30 days of the veteran's desired date.

In fiscal year 2006, which was the last fiscal year, the VA provided 39 million outpatient appointments to 5.3 million veterans. Ninety-five percent of those were provided within 30 days of the desired date, 98 percent of those were provided within 60 days of the desired date. And, most of those outliers were appointments for sub-specialty needs in other clinics.

We also implemented the Advanced Clinical Access Program as a process to speed up the appointment process and it has worked very successfully. Because this is pretty extraordinary when you think of the volume that we do, that 95 percent of them get an appointment within 30 days.

Now, I would also like to say if you have an incident of that or if a veteran has talked to you with that, I would very much appreciate if you would bring that to me with specificity, because I will direct the Inspector General to look into that. Because if that is happening, that is unacceptable even on an isolated incident and we will investigate that.

Senator Byrd. Right? Now this is a second question. Will you look into this again and respond to the subcommittee?

Secretary Nicholson. Yes, indeed. I will look into it, and I will repeat and say that if you have the specific case or incidences, it would greatly help us in looking into it.

Mr. Chairman, I want to thank you and I want to thank all members. And, I want to thank the witnesses.

Senator Reed. Thank you very much, Mr. Chairman.

Senator Byrd. Yes, sir.

Senator Reed. Senator Hutchison, your questions please?

Senator Hutchison. Thank you, Mr. Chairman. I want to start with the issue of the claims backlog, Mr. Secretary. I know that you have said that you are appointing patient advocates and more claims adjusters. What do you--what is your goal to try to get this backlog really alleviated? I'm told that the current backlog is over 400,000, and you're saying 800,000 new claims are coming in annually. I sympathize with you--that is a huge workload.

One of the things that has been suggested is that you maybe transfer some of the claims adjustment issues from regions that are overloaded to regions that might not be as overloaded, is that something that you're looking at? What is your plan to address this comprehensively?

Secretary Nicholson. Well, first to your specific question at the end there, Senator Hutchison, we are doing that now. We're, the term of art that they use is ``brokering'' in that where a regional office might not be as loaded as another, we take bundles of claims to those, and have them evaluated by that office. They all use the same criteria, so they're, in that respect, able to do that, there's no jurisdictional border that would prohibit that.

This is a beguiling problem. In a way we're kind of the victim of our own success, because we have a very active outreach effort going on, and education program going on to inform veterans, to inform Active duty members of the potential of benefits that may be available to them at the VA. In fact, we have VA personnel embedded at over 140 military establishments today, whose mission is to talk to people who are on the verge of getting out of the service. So that they know what is available, what they've earned, what they may be eligible for. We also have implemented a program called benefits during discharge, which allows us to accelerate the adjudication of a claim for a, about to be, or just departed Active duty member, and that has helped.

This backlog, by the way, has come down--a few years ago is was like 212 days or something--and I would say, and I would commend the people in the Veterans' Benefit Administration because they really are working hard, we had 806,000 come in, and they----

Senator Hutchison. Could I?

Secretary Nicholson [continuing]. Processed almost that many.

Senator Hutchison. Could I interrupt you for just a minute, because some of the people who cause this backlog are people who are coming in asking for benefits long after they have served, so it could have been in the Korean War or Vietnam or something. So, that is one category.

But, do you prioritize people who are coming out right now, and particularly those who are injured? Is there a strata where you put people who are injured in Iraq, Afghanistan or any Active Duty, or any person now serving Guard, Reserve, whatever, do you make that a priority? So that somebody who's leaving because they're--they've lost a limb, or they have severe disabilities gets a, more immediate action?

Secretary Nicholson. Yes, we do, Senator. We prioritize the

returning OIF/OEF, Iraq and Afghanistan veterans, we prioritize them, and we prioritize the claims of veterans who are 70 years old, or older.

Senator Hutchison. Okay.

Secretary Nicholson. And we have special teams that are working to expedite those claims, in both cases.

Senator Hutchison. Okay. Well, I just want to highlight, and I have, and you have responded, that this has to be taken care of.

I want to ask a quick question, and then I hope I have time for----

Senator Reed. There will be a second round.

Senator Hutchison. Okay. Quick question on the study for south Texas for a Veterans Hospital--it just seems like it's been over--I know it's been over a year, that seems awfully long--could you tell me the status, and can we expect a report? We're told now, July--is that a set time, and I'd just like a status report on that?

Secretary Nicholson. The study is still ongoing, and we do expect it to be completed in July, yes.

Senator Hutchison. Thank you. Last question, or, for this round--the data security issue--I just can't not address that, since it's been in the news so much lately.

We understand that Mr. Howard in your agency has begun using a Fidelis testing software to monitor VA employees' compliance, in addition to all of the education that you are giving to employees, regarding the need for this privacy and security of data.

However, the testing software showed that there were--just in the week of March 5-11, 2007, violations in the Boston VA, of the security procedures. Can you tell me if you--how you think that happened, after all the education efforts, and what you are doing to assure the privacy of data of our veterans?

Secretary Nicholson. Well, first of all, in a transcendent way, we're totally transforming the IT system in the VA. We've moved thousands of people from a decentralized format to a centralized format under the cone of the Assistant Secretary for IT, which is General Howard.

We have intensive training going on, we're trying to reculturate the entire organization about the seriousness of data. It's handling, and it's security. And, we're making considerable progress. We have, taking the personal laptops and computers, personally owned, from people and giving them Government computers, we want the information on there to be encrypted. But, we're still dealing with human beings, some of whom have bad habits, and some of whom still have an overly lax attitude about the severity of this. But, I would say that we've made a lot of progress, we're encouraging self-reporting, we get those Security Operation Center reports every day, and people, I think, are quite forthcoming about the reporting of it, we take immediate corrective action if it's a serious episode.

I'd like to invite, if I could, General Howard, if he would like to add anything specifically, particularly with regard to your question about the software.

Senator Hutchison. Yes, I should have addressed that to you, thank you.

General Howard. Senator Hutchison, the software you're referring to is one of several products that we're testing right now, Fidelis. The incidents you refer to were a result of the testing we were conducting, and just to let you know that what that was, monitoring activity, e-mail-type activity over the network. This particular software has the capability to terminate sessions, based on certain rules, and that's why we're very interested in it, and that's why we uncovered emails that were transmitting large amounts of information that should not have been transmitted. In fact, there were several of them that were serious enough that we actually reported them as ``incidents'' and those are the ones that you're referring to.

What has happened to the individuals who were involved in that, I'm not sure. They were in the Veterans' Health Administration, I think. Dr. Kussman is looking at that. There weren't a lot of them, but there were several.

And I'll just summarize, the software like this we do intend to deploy, along with other techniques to help us better control activity on our networks.

Senator Reed. Thank you, Senator Hutchison, and the vote as we have realized, has been delayed, and we will have at least two rounds, so I think everyone will have ample time to ask questions.

Thank you, Mr. Secretary, for your statement today and your response to questions.

Let me agree with you that 177 days is just much too long to process a claim. What is your target date in terms of your, ordering your or requesting your organization to manage down to?

Secretary Nicholson. Well, the ultimate target date, Mr. Chairman is 125 days. But, because of the prioritization that we're giving to these young combatants returning from the War, I've put down a marker for us to do those in 100 days.

Now, this is a complicated process, and it would take up quite a bit of the time of your hearing to really give you a primer on it, but I'll do it in a truncated form, and maybe use an example.

A veteran comes into us--and by the way, veteran's claims are never res judicata--ever. They can continue to bring them back, if they're denied on an appeal, they can re-apply, if they get an award at a certain percent, they can come back in and, they are never finished. And, of those 800,000, roughly, that we saw last year, about half of them had been in there before.

The Congress and the courts have afforded continual rights to the veteran claimants, and I'm just stating this, I'm not evaluating it or editorializing on it. But, for example, if a claimant comes in and said, ``I have, an arthritic knee, and I got it, I know I got in a parachute jump in the 82d Airborne Division in 1988,'' we must, in our fiduciary, go back and see, one, was the guy a parachutist? Was he in the 82d? Did he jump on that day? Did he go to the dispensary because he said he hurt his knee? And we need to find evidence of that, and those paper files, non-electronic, need investigating. And, if we need to go back to a veteran claimant and say, ``We need more verification or another document,'' he has 60 days, each time we do that, he has 60 days within which to respond to us.

The culmination of this is while we can shorten it, and we're going to mobilize on this OIF/OEF on a test basis to see if we can't do that in 100 days, and they will have to work with us--it has some organic difficulties.

Senator Reed. I recognize the complexity, because we have veterans coming through our offices every day asking for assistance. But, if your target is 125 days, do you have the resources in this budget, and succeeding budget plans to meet that target for all veterans?

Secretary Nicholson. In this budget, as I testified, we are asking for resources to increase claim evaluators in the amount of 450, and again, they take a fair amount of training, but we project that would reduce it to 145 days.

Senator Reed. So, we still have a ways to go, to get----

Secretary Nicholson. Still have a ways to go to get the 145.

Senator Reed. Thank you, Mr. Secretary.

Mr. Secretary, let me also commend you for the screening of all OIF/OEF veterans for traumatic brain injuries, and it's a great first step, but can you tell us what the next step is, after that? After you've identified these individuals?

Secretary Nicholson. Yes, sir. As I've said, we're going to screen all of them now, and we've just about completed the training of all of our staff, our clinicians, to be able to do that. And then, they will commence a treatment regime for those that have any showing of either mild or moderate brain damage. I attended yesterday a session we had with DOD on this subject, so I learned a lot just yesterday about this, but it's often very difficult to discern whether or not they have any physical symptoms of it at some point.

But we are being very diligent, we think, and of those that--through their answers to the questions that we give them seem to indicate, because of some experience, some moment of forgetfulness or something--we would then refer them for a neurological assessment. I think we have set up a very good program.

Senator Reed. One of the difficulties is that once the person leaves the military, they leave the post, and the post hospital, and the whole structure, very structured environment, and go off to their--many times--small towns, where the VA doesn't have a huge presence. Are you reaching out to private clinicians to be able to treat these individuals who are identified with traumatic brain injuries, and doing it in a systematic way?

Secretary Nicholson. We have been having some meetings, in fact, we had one in my conference room recently with the Association of the Private Rehabilitative Clinics, and we are interfacing with them, and we have a policy--if we cannot provide that kind of therapy and care to a veteran on a reasonable basis, we then can allow them to go out to the outside on a contract basis, and get this care, yes.

Senator Reed. And, are you programming funds for this activity in this budget and succeeding budgets?

Secretary Nicholson. Yes, we are. I'll ask Dr. Kussman to maybe give you more detail, Mr. Chairman.

Dr. Kussman. Thank you, Mr. Secretary.

The Secretary has alluded to the fact that we have this

screen, and on the basis of the screen, if the questions are answered positively, they get a referral for a neuro-cognitive assessment, that is not as easy as it sounds, as you know. There's no x-ray or blood test that can be done to assess it, but further evaluation would then determine what kind of treatment, if anything.

We're fortunate, the few studies that have been done are looking at mild to moderate TBI, longitudinally, long term, have shown that most people--thank goodness--will get better. And, so the important thing is to be able to identify them, and then follow them, in making sure that they get better, and if they don't, do everything possible to assist them.

We do need to aggressively assist the civilian community, because as you allude to, the average practitioner in the country probably doesn't have much experience with TBI, and that's a fertile area that we need to look at.

Senator Reed. Thank you very much, Doctor.

Senator Craig.

Senator Craig. Mr. Chairman, thank you very much. Let me make a comment more than a question, because as the chairman, now ranking member of the authorizing committee, I've had an opportunity to look at the budget of VA, to the extent that we've even offered views and estimates necessary to go to the Budget Committee, so that the budget that we now have in front of us to appropriate to, I've already screened.

And so, as a result of that, I want to make this statement, and then ask a question.

Mr. Chairman, just 2 months ago, the Veterans Affairs Committee held the hearings on the budget. At that time, I remarked to Secretary Nicholson that it must have been a little difficult to develop a budget without the knowledge of the fiscal year 2007 appropriation, because we had not yet passed it. As everyone knows, we now have passed the bill, the VA received about a \$3.5 billion increase in funding relative to the 2006 budget. Of course, not long after the bill passed, we also passed a supplemental appropriation for, fiscal year 2007, which added another \$1.7 billion, bringing the total increase for this year to about \$5.2 billion, or just over a 15.5 percent increase. Most of the money is for the medical system which, assuming enactment at some point of a supplemental bill, will have about \$35 billion this year.

Mr. Secretary, you've requested about \$36.5 billion for medical care for next year. A few months ago that was a pretty strong increase, of about \$2.9 billion. However, at this point, your increase would be about \$1.3 billion over what you're likely to have for the rest of the fiscal year.

Further, the Senate has gone on record as suggesting that we need around \$40 billion for medical care, alone, next year. The money is coming in, in my opinion, in huge waves.

Mr. Chairman, I recognize that returning troops from Iraq and Afghanistan are going to require a substantial infusion of money over the long term. And, I am committed to doing everything and anything we can to help the men and women who return from war injured, physically and mentally. I have even suggested that we should let them go outside of the VA system, where necessary. And we just have had reports this morning coming in, that maybe in the area of prosthesis and other

areas, where VA is not yet geared up, and yet the private sector is clearly out there in advance of that, that some of our military people ought to be able to go there, or our veterans.

But right now, I fear, we are almost throwing money at VA, with little planning on the part of the Agency as to how it could possibly be spent. And then, 6 months from now, we are going to hold another hearing, asking the VA one of two questions, Mr. Chairman: Why didn't you spend it all? That will be one of the questions, or, Why didn't you spend it all wisely?

I hope we are mindful of those possibilities during this fiscal cycle. Additionally, Mr. Chairman, I know all of us here at the committee are concerned about VA's claims processing systems, and problems, I'd like to suggest that maybe money isn't a solution to all of those problems that plague the VBA. With the additional employees VA has requested for fiscal year 2008, VBA staffing will have a increase 61 percent since 1997, and funding for compensation and pension service will have increased 118 percent. Yet probability--but productivity has been deteriorating, and the number of pending cases has been on the rise.

And while more staffing may help, I don't believe that simply adding more employees is a long-term solution to the problem. For many years, experts have stressed that significant improvements may not be possible without fundamental changes in the system.

A 1996 Veterans' Claims Commission concluded that problems with the existing systems are so many and varied, that it cannot be fine-tuned into a system that will consistently produce timely and high-quality adjudication products. After years of struggling to improve the performance of the existing system, it may be time to acknowledge that those experts were right--that fundamental changes are needed before we see the kind of lasting improvement we desire. And, Mr. Secretary, I am pleased that you are moving in that direction.

Those are the issues that concern me. The question is, Mr. Chairman, the 2007 supplemental--Mr. Secretary, the 2007 supplemental and the budget resolution of 2008, which provide VHA with about \$5 billion more than your agency believes is necessary to fund operations--question, Do you believe VA can responsibly allocate that level of increased resources in such a short period of time? And what might be some of the challenges or issues you would encounter in planning to spend that amount of money?

Secretary Nicholson. Well, I think it's a very good question, Senator Craig, I mean, we're a big agency with over 1,400 points of where we dispense medical care, from Maine to Manila and we have a huge benefits operation going on, given also the real estate stock that we have, and the age of it, we probably could always use, use more resources.

A very important part of the question to me is, can you spend it within the timeframe that you're supposed to? And sometimes, I think to do that prudently, is difficult. We have had incidents where we've been given more money to spend in mental health. That money, though, was subject to a CR, the CR, late in the fiscal cycle was released, and in that envelope

that we had left, we did not spend it all, and we were criticized for that.

But, the reason for that--and the same applying prospectively--is that we're talking about people with real specialties, and, they don't all grow on trees, and they're not all willing to move to certain locations, to be there where we want to set up a Center of Excellence, or where we have a particular need, so we have to recruit them. And these things take, they take time.

So, I think the time part of it, is one that I--couldn't sit here, and certainly couldn't under oath say we could spend all of this within the prescribed time of that fiscal envelope, no.

Senator Craig. Thank you.

Mr. Chairman, thank you.

Senator Reed. Thank you very much, Senator Craig.

Senator Allard.

Senator Allard. Thank you, Mr. Chairman.

First of all, I want to recognize the improvement that's happened at the VA in the past several years. Some of it started before you assumed your term, so I have to credit your predecessor as well, but I think you've continued to improve on it, and I note that the American Customer Satisfaction Index, on their seventh consecutive year says that VA has earned higher marks in the private healthcare industry--this is on customer satisfaction--and I think you're to be commended about that.

Colorado, as you're well aware of, has experienced a bigger, and a more important role, as far as our National defense is concerned, in many aspects, particularly as we move toward a modern military. And, I would say, before 9/11 that the healthcare that we provided our veterans in Colorado, at best, was marginal.

But, the Veterans Administration has been willing to make some tough decisions in Colorado, we closed a VA hospital--how many times does that happen in a State? And, in replace of that, we put in some regional clinics. And, so, what it did, was made medical services much more available to a segment of the population that weren't being well served.

And, the input that I'm getting from those veterans in southern Colorado, where that was located, has been very positive, since they appreciate the fact that they have these clinics.

And one aspect in going through these clinics, and personally visiting them that--we've looked at is their electronic record keeping and everything, and it's phenomenal. And, I think that's added to that, also, I hope you continue that.

I would like to join with Senator Hutchison in saying that we need to work on getting a transition from active military over to the veterans. And, I understand how complicated that could be, particularly if they come back home, and maybe they, then they re-enroll or something, back and forth. But, I do think that's something we really work on, and I think it's a doable thing, but we need to work on compatibility in our programming.

In--so, you know, with the closure of the Fort Lyons

Hospital and then those clinics opening up, Colorado, and those veterans feel well served. We've had a hospital in Colorado that has--you know, as far as medical care been doing pretty good, but it's just been getting outdated and old. And, as a result of that, you've recognized that need, and now in the Denver area, you're in the process of putting together, and constructing, we made the land agreements and everything, putting a plan together for a Veterans' Hospital in Denver to serve the entire Rocky Mountain Region, and provide some very, very high quality care, I'm convinced.

And, I understand that Veterans' Hospitals don't come cheaply, and I appreciate your recognizing the needs--which are rather unique in the State of Colorado, because of our growing veteran population--people get assigned there, they decide to come back there and retire. And, so we're experiencing unprecedented growth, I think, in the veterans population, but your modernizing the VA has helped, and I think, provide good care despite that stress.

Now, I've asked you to update the committee, what plans you foresee for the Veterans' Hospital there at the Fitzsimmons site in the future, and how you plan on meeting--you've got an additional amount in the budget of \$62 million or so, which is an increase from last year. Now, we're going to have some expensive years ahead of us, now, we get into actual construction. Could you kind of indicate to me how you plan on generating the revenue, and what you plan on doing with those extra monies that's going to be needed to finish the construction of that hospital?

Secretary Nicholson. Yes, I can, Senator Allard.

We have slightly over \$100 million approved so far for that project, as you know, because you've worked on this, and been very helpful. We've chosen the architect engineer, we've acquired the major part of the site for this, after months and months of negotiation with the city of Aurora to put this hospital out where it belongs, which is right next to the interstate highway, and right next to the University of Colorado Hospital, with whom the VA has been affiliating for over 50 years. In fact, it's interesting for some people to know that the first liver transplant ever--successful liver transplant ever done on a human being was done at the Denver VA Hospital, in consult with the University of Colorado.

We will now continue to assemble the rest of the ground that we have, so we have the resources for that, and to do the design of the hospital. We, though, must come back here to the Congress, and get the subsequent approvals for the funding that it's going to take to build and finish the hospital. Assuming that we get that, we believe that we can have this hospital open sometime in 2011.

Senator Allard. You think you can get that in the President's budget request? A good chance?

Secretary Nicholson. Yes, sir, I do.

Senator Allard. Okay, very good.

I'd like to--discuss other Colorado business, because of our unique growth in military retirees as well as veterans, we have sort of a unique situation in the Colorado Springs area, in the fact that there's an increased demand for a cemetery to serve those that are in southern Colorado. And, I've introduced

some legislation to take care of the Pike Peaks Region. I understand the challenges you're having with the number of people that you have to have to justify a cemetery within a 75-mile region, and we've been visiting with Mr. Tuerk more, with this.

And, so, I'm going to address this question to Mr. Tuerk, if I might. You mentioned in our discussion that it is not necessarily set in stone. That there are exceptions you have, maybe it's not easy to get the exception but it is possible in some unique situations, maybe, to get an exception.

You mentioned last year that the formula, again as I stated, was not set in stone. Could you advise us on the progress of updating the formula? To be more accommodating to some of these unique situations, such as the Pikes Peak Region?

Mr. Tuerk. Yes, Senator, I'm happy to have the opportunity to do that.

The policy that we have adopted, and that the Congress has adopted in directing where we will locate new cemeteries, as you know, states that a new cemetery will be placed in a location that has 170,000 veterans, who are not served by another existing National or State Veterans cemetery. You're certainly correct that Colorado Springs is an area of significant growth--by our estimates there are 261,000 veterans, within 75 miles of Colorado Springs.

The question, though, for purposes of our determinations and, heretofore, the Congress's determinations on where we ought to go, is how many veterans, within proximity to a given city, aren't already served by an existing cemetery. You understand how that plays out with respect to Colorado Springs vis-a-vis Fort Logan National Cemetery, southwest of Denver.

It is correct, as you said, that no formula is set in stone. We try to be flexible in making our determinations of where to put resources, and our recommendations to Congress on where it should decide our resources ought to be placed. And, when I say it's not set in stone, I mean it is subject to change.

As we have discussed, I have commissioned a program evaluation by an outside consultant to look at our methodology for siting cemeteries to consider factors that you have brought to my attention, that Senator Salazar has brought to my attention, and members of Colorado's House delegation have brought to my attention about traffic issues between Colorado Springs and Fort Logan, and the significant growth the significant military presence, in the region. We have instructed our consultant to take those factors into account as it critically looks at the way we site cemeteries now. That program evaluation is in progress. We have hired a contractor, and we have set him off to work. He will report next year. He has not yet completed his analysis of the methodology that we have used to date on siting new cemeteries.

Senator Allard. Well, then, you know, if we could exclude the Denver area, which we talked about, just the Pikes Peak Region, we've come up with 175,000 population, we talked about the Region, we pull in the area south of Colorado Springs and go south, we can come up with 175,000 on that. So, take a close look, and I'm glad to hear that you're working on the formula and looking at the unique aspects of Colorado and the situation

there.

Fort Logan which is also, is the cemetery you mentioned in southwest Denver--I've had some personal experience with that in the last year or so, we buried both of my wife's parents in Fort Logan. It's a great facility, but in visiting with those, you know, it doesn't have too much--there's still some capacity there, but you know, that capacity in 10 years is going to be gone.

I, as well as you, know it takes awhile to get cemeteries built and get them in line, so I hope you keep that in mind when you're doing that. Thank you.

Mr. Tuerk. We are very mindful of that, Senator. We are developing the last 66 acres of the Fort Logan site. We've encountered a problem with respect to some of it, that we can't turn into burial space. Right now we project that Fort Logan will continue to offer burial services until at least 2020, and we are very mindful of that, and are thinking ahead on where we might go to continue to provide services to the Denver/Colorado Springs area at the point in time when Fort Logan will have to close.

Senator Allard. Thank you very much for your comments, and I have some additional questions on the second round.

Senator Reed. Thank you very much, Senator Allard. We have a vote under way right now, for your information. And Senator Murray is voting, and she will join us shortly, and I'll begin the second round, Mr. Secretary and, Senator Craig raised some very interesting questions about the capacity to spend money, and I guess one point should be noted, is that in the Senate supplemental for the VA funding is ``no year'' funding, meaning that you will not have a specific amount of time to spend it, so that will give you a little more flexibility, we hope, going forward.

I just would note, and Senator Allard has left, but the Denver Post reports that nearly 2 in 10 Fort Carson GIs got brain injuries in Iraq. They're screening. Which, if you do some back-of-the-envelope calculations of the several hundreds thousands of troops that have gone through Iraq and Afghanistan, if 20 percent is the number, that's going to present the VA with a very huge increase in very complicated cases, going forward.

And it raises, perhaps the flip side, of Senator Craig's question, which is, do you have a number right now, going forward over the next--over the next 10 years, of how much we're going to have to devote to caring for these veterans?

I've asked the same question of Dr. Chu on the DOD side.

Secretary Nicholson. The answer is no, we do not, Senator. We monitor very closely, but we have not projected it out to a 10-year number, no.

Senator Reed. Well, Mr. Secretary, I think that's something collectively we have to do. Because the fear I have, and I think it's your fear also, is that at some point in time, when this situation has been resolved one way or the other in Iraq, Afghanistan, we'll still have these veterans, and it will be a disservice to them at that point, when the attention has waned, not to have at least understood the demands we need.

And that also goes to the budget numbers that I've seen so far. You, quite rightly, reference the increase in the

President's budgets, particularly for healthcare over the last several years, but if we look at the 5-year discretionary budget projections for VA medical care, it shows no growth at all. According to the historical tables that accompany the 2008 budget request, hospital and medical care will actually decrease slightly by 2012. And, again, how realistic is that if we're looking at these, this patient flow coming into the system?

Secretary Nicholson. Well, we've used a model, Senator Reed, it's proprietary, it's operated by a company called Milliman and over the years they've been very uncanny, accurate, not without exception. But, there is a decrease in the number of veterans in the country, on a net basis, because of the mortality rates. I would ask Dr. Kussman if he'd like to add anything to that medical projection.

Dr. Kussman. Sir, as far as the severe TBI--the number that had been transferred to us throughout the war is 369 severe trauma, that have come to our polytrauma centers. No one really knows the number of mild to moderate. And, that's why we're putting this screening mechanism in. I think that at Fort Carson, it's a similar type of screening. We've worked with DOD and so, these are new numbers.

As I mentioned earlier, hopefully these mild to moderate TBI, as I said, frequently will get better on its own and hopefully won't need a lot of care, hopefully these service members, who have suffered this, will return to whatever their baseline was before they suffered the injury.

But, it's a very important thing. We need to get the information. This is a very important issue for us and we will monitor it very closely.

Senator Reed. Well, I would suggest that, perhaps, the model has to be reviewed significantly. And, I do think we need a--at least a conceptual notion of how much money, going forward, we're going to need. And, not just the next 5 years, but these young people are going to be in your system for 50 years, probably.

And, let me ask a final question before I turn it over to Senator Murray and ask her to continue.

One of the issues that's consistently in the public view, is homeless veterans. And, it seems to be a contradiction in terms, that someone who's served their country in the uniform of the country should not be without a home. There are some programs that have been proposed. And, one is a innovative program between the Veterans Administration and HUD where section 8 vouchers are combined with VA-supported services. That fund, that program has not been funded to date at any robust level. But just your opinion, Mr. Secretary, if that's the type of approach that would make sense in terms of dealing with this issue of homeless veterans.

Secretary Nicholson. Yes, Mr. Chairman. In my opinion that would be very helpful. We have some microcosms of that. In fact, I'm going next month, I think, to open a facility that we've done in south Chicago in the old St. Leo's Parish Corner, we've done with Catholic charities there in Chicago and, and using HUD Section 8 to support the transitional housing costs. We've also sited a clinic on that facility. That's an excellent model.

I was very recently in San Diego with Chairman Filner at a place called Veterans' Village, where we were supporting a lot of transitional housing there. That has a great deal of promise, I think, and it's the right model. Because what we do is, we support a non-profit sponsor who operates the facility and we help in its construction and then we have the per diem maintenance for the veterans who reside there. But we need more of that.

Senator Reed. Thank you, Mr. Secretary. Let me just say we'll keep the record open for three additional days if there are questions from members of the panel.

I'll recognize Senator Murray. I'll endeavor to get back after the vote, but if I don't, you finish your questions. Feel free to conclude the hearing.

Thank you.

Senator Murray [presiding]. Thank you very much, Mr. Chairman and thank you, Mr. Secretary.

It has been a couple of months since you testified before the Veterans' Committee so, you know, I've been amazed at the number of things that have occurred since then. Obviously with the Walter Reed issue and the growing awareness of facilities across the country with needs, the internal VA report that showed the problems that need to be addressed and, of course, we have learned a lot more about the signature issue of this war, traumatic brain injury and the number of men and women out there who have been impacted that--some of them not yet caught. And, I appreciated some of the work you're doing to find those men and women and make sure we address that extremely important issue.

The Senate has now passed a budget for fiscal year 2008 that provides the VA with more money than the President's budget for medical care, for IT, medicom prosthetic research, and a lot more. I wanted to ask you. Do you support the higher level of veterans funding in the Senate Budget?

Secretary Nicholson. Well, we've had a lot of consultation with staff on those amounts and the application of them and the way that we would utilize them. We, as part of the administration, have submitted a robust budget for 2007 and felt--and it was eventually approved and--that that is a solid budget. But, we can use, if you so choose in the Congress, we can make good use of the money.

Senator Murray. And the additional money that is in the supplemental for polytrauma care and other issues for healthcare for veterans. I assume you would be supportive of that as well?

Secretary Nicholson. We can use it, yes ma'am.

Senator Murray. I appreciate that very much.

We've talked, I heard you talk a little bit about polytrauma care. We have \$90 million in that supplemental. I think this is an issue that we all have got to put down everything else we do and really address those issues. So, I appreciate it.

I did want to ask you a little bit about the TBI. We are ready to give you the resources you need. I know that you're screening Iraq and Afghani veterans for TBI now and I think it would really be helpful for the VA to start that screening process a lot sooner.

Back in August 2006, the Pentagon Medical Board proposed that the Defense Department begin tracking which service members were exposed to IEDs on the battle--even those without physical injury or serious at the time--because we know the shockwaves have an impact on the diagnosis of TBI. Do you agree that it would be helpful to the VA if those men and women were diagnosed before they left the service, or at least that you knew they'd been in the vicinity of an explosion before they entered the VA system?

Secretary Nicholson. I'll give you my view and then I'll refer to Dr. Kussman, who is the Chief Medical Officer of the VA.

I think that it would be useful because the sooner that we can detect it, the sooner that we can begin to treat it, and thus, the sooner we can bring about healing.

Senator Murray. Yeah.

Secretary Nicholson. And, through therapy and treatment. Now, I ask Dr. Kussman if he'd like to expand medically.

Dr. Kussman. Yes, sir. Thank you.

Yes, Senator, we've been working with DOD to develop an adequate screening mechanism. As you know, it's hard to do that because there's no test, as I mentioned earlier, or no blood test that you can do to make the diagnosis. I think we, with the DOD and the VA, do very well with severe TBI. Those people get into the medical evacuation chain and I think that together----

Senator Murray. Well, it's more a physical injury.

Dr. Kussman. That's correct. But, as far as the mild to moderate, one of the challenges is, and the difficulty is that the patient frequently doesn't even know they have it.

Senator Murray. Right.

Dr. Kussman. And so, we've developed a very, I think--and time will tell how accurate it is--but a good screening mechanism using the best knowledge from the civilian community, DOD, and us to ask people when they come in, everybody who is OIF/OEF, and we hope that DOD will use that as well during the post-deployment screen. On the basis of that, if the person answers yes to the questions then they would be referred for a neural cognitive evaluation by the subject-matter experts and then they determine what kind of treatment, if anything, needs to be done. Because, as you know, some of the mild or moderate do----

Senator Murray. But, Dr. Kussman, I've talked to a number of the doctors at the polytrauma centers who tell me that there isn't necessarily a set of questions you can ask and know. And, in fact, the soldier may not even remember that he was in the vicinity of a, of an explosion in certain cases.

Dr. Kussman. That's what makes it so challenging, but we need to have a least some mechanism for asking the right kinds of questions.

Senator Murray. Yeah, that's why I was asking, if it would be helpful for the Pentagon to track battlefield exposures to IEDs, and then share that information with the VA.

Dr. Kussman. If there's a mechanism for them to identify everybody who was near an IED, particularly ones that have been in contact with more than one IED. That would be very helpful, yes.

Senator Murray. Well, Secretary Nicholson, would you be willing to write a letter to Secretary Gates and ask him if they would begin to track that information and share it with you so that we can make sure we don't lose these men and women?

Secretary Nicholson. Yes, I would be willing to write him a letter. He serves on the taskforce, the inter-Cabinet taskforce that I chair on OIF/OEF heroes. And, discuss that it was brought up in this hearing and ask him to consider it. Yes, I would.

[The information follows:]

Secretary Nicholson sent a letter to Secretary Gates dated May 14, 2007 encouraging the tracking of all soldiers at or near the site of an improvised explosive device (IED) incident so that soldiers could be closely monitored for subsequent health changes. In addition, the VA Deputy Secretary Gordon H. Mansfield and DOD Deputy Secretary Gordon England have already held discussions and as a result the topic will be brought before the DOD/VA Joint Executive Council and the DOD/VA Health Executive Council (HEC). The next HEC is scheduled to meet on May 24, 2007.

Senator Murray. Okay, I would appreciate that. I think it would be helpful. I've talked to too many of these young kids who, not many of them are young any more, are a year and a half after they separate, all of a sudden their family recognizes they are not tracking correctly, they can't remember things, whatever their issue is. And, if we can get them in sooner than a year and a half later, it would be great. I think if the Pentagon were able to share that information with the VA, we would be in a much better place to find them before they're lost for a year and a half of their lives. So, I would appreciate if you would be willing to do that.

Secretary Nicholson, I also wanted to ask you, I saw in Salon.com yesterday a report on a focus group that the VA conducted at Walter Reed with Iraq and Afghani troops and their families way back in 2004. And, the focus group found that injured soldiers at Walter Reed were frustrated, confused, sometimes angry with the bureaucratic problems at Walter Reed. Were you ever briefed on that focus group report from 2004 about Walter Reed?

Secretary Nicholson. No, I was not, Senator. And, I asked Dr. Kussman about it this morning. And so, I'll ask him to respond.

Dr. Kussman. Yes, Senator, I certainly read that report as well. As you know----

Senator Murray. Read it yesterday, or read it----

Dr. Kussman. No, I meant I read the----

Senator Murray. Article.

Dr. Kussman [continuing]. The Salon.com article. I'm aware of the report. That report was generated about 9 months into our seamless transition activities related to OIF/OEF. And, it was directed by the Chief of Staff at that time, this was before Senator----

Senator Murray. Right.

Dr. Kussman. I mean, Secretary Nicholson came. And, the effort here was for us to look at what our benefits counselors and social workers were doing, whether we were getting the

information across to these veterans. We learned there were about six veterans and some members of families that came, obviously a small sample, but the effort here was to learn what we were doing well and not doing well.

And, we did learn a lot of things. Several things came out of it about improving information, improving communication, when we should interact with the veterans. This taskforce was a multidisciplinary with that there were representatives from DOD there on the committee. The report went to all the members of the Committee, but it was geared to look at what the VA was doing over at Walter Reed, and determining whether we were accomplishing our mission.

Senator Murray. Yeah, it's just, it's troubling that, that long ago there was a report somewhere that these issues were festering over there. And, it was not shared with anybody at the VA at the time?

Dr. Kussman. Oh no, it was. We knew about it. Again, most of that had to do with our questions related to, and again small numbers, but related to whether the VA was doing its mission.

Senator Murray. Was there follow-up then, after that?

Dr. Kussman. There was a very thorough action plan that was established after that to address the issues of communication, timing of visiting, repeating visits. And, that was part of the reason we set up our seamless transition office. Because prior to that, it had been a task force that was established and we needed more effort.

Senator Murray. But, was that focus group information shared with the DOD?

Dr. Kussman. As I said, there were members from the DOD on the committee, but it wasn't directed to what DOD was doing.

Senator Murray. So, the DOD was aware of that report.

Dr. Kussman. There were DOD members on the committee.

Senator Murray. Was it shared with the White House?

Dr. Kussman. No, I don't believe it was shared with the White House.

Senator Murray. But, the DOD was aware of it, as well.

Dr. Kussman. There were members on the committee.

Senator Murray. Okay. It's just troubling that it all came to light years later. Okay well, let me ask a few parochial questions in my few remaining minutes and I will turn it over to Senator Allard.

Secretary Nicholson, while you're here today, I wanted to ask you about the Wenatchee VA clinic. You know, it was supposed to open this spring, it was pushed to August, and now we're told it's going to be September. Can I have your assurance that our Wenatchee VA clinic is going to be open, and that you're doing everything in your power not to have another delay for these folks who have been waiting for this for years?

Secretary Nicholson. I'm going to have to defer to Dr. Kussman, or get back to you in writing.

Can you respond?

Dr. Kussman. I have to apologize. I don't have the specifics, but I can assure you that it's on the list and we'll do everything we can.

Senator Murray. It's been on the list forever.

Dr. Kussman. Well, we'll look into it and get back to you.

[The information follows:]

The lease for 13,000 sq ft of space at 2530 Chester Kimm Road, Wenatchee, Washington, was awarded November 16, 2006.

--The design phase for the new clinic was completed on March 20, 2007.

--Negotiations regarding tenant improvements concluded March 28, 2007.

--The Notice to Proceed was issued April 2, 2007.

--Construction commenced on April 3, 2007.

--Under the 100 day agreement, construction must be completed by August 22, 2007.

--Activation of the clinic is projected for September 17, 2007 and is still on target.

--The VISN will continue to provide regular updates on the progress to congressional and other stakeholders.

The VISN office provides periodic updates on the status of the clinic with scheduled monthly reports.

Senator Murray. Okay. Well, they've waited a long time for this. And, there was a lot of expectation it was going to be open more than a year ago. Then we were told this spring, then it was August, now it's September. And, nobody believes us anymore, that this is going to open. So, I just want your assurance that you can make a call, Mr. Secretary, and find out where this is, and move it along?

Secretary Nicholson. Oh, yes, I'll do that, promptly.

Senator Murray. Okay, very good.

I have several other questions that I will submit for the record. I wanted to ask you about Walla Walla. I asked you about that before and haven't received any response back on that, Mr. Secretary. If you can get back to me on some of the mental healthcare issues on Walla Walla, I would really appreciate it.

[The information follows:]

The VAMCs in Walla Walla and Spokane will cooperatively manage inpatient mental healthcare for the Washington, Oregon and Idaho counties in their service areas. This will include residential rehabilitation care for substance abuse and PTSD provided mostly at the Jonathan M. Wainwright Memorial VAMC in Walla Walla and through community contracts in Spokane. Inpatient psychiatry will be provided at the Spokane VAMC in Spokane, Washington and through community facilities in Lewiston, ID and Yakima and Tri-Cities, Washington. Expanded outpatient mental health services will continue to be provided at the VAMCs, the existing and planned community based outpatient clinics, and in other locations as determined.

Senator Murray. Thank you very much. And, I will turn it to Senator Allard.

Senator Allard. Thank you. Mr. Secretary, another issue that has been brought to my attention last week--I think you were hanging around Colorado about that time--is that your agency had done some inspections on some nursing homes in Colorado. And, as you know this is a partnership between the Federal and State. I have visited one of those nursing homes, it's probably the one that passed. There's five of them

altogether, I think, that we had there that were inspected. And, four of them were criticized in the report and I think they, the way they described it is that four nursing homes underperformed but only one of five had patient-related quality care issues. So, apparently the patients were getting pretty good care.

But I was curious to know what there was about that report that was so troubling. The one facility that I went to is the newer facility and I was most impressed, by it and with the staff as well as the facilities there. So I doubt if that's the one. The one there at Fitzsimmons. I doubt, that's probably the one that passed is my guess. But, I'm wondering what, on the other four, can you share with me about what was going on there that was of concern to the inspectors? I suppose Colorado has to take some strong initiative here to begin to brief these up. What it is that we can do to encourage and to move forward on that?

Secretary Nicholson. Yes, Senator Allard, as you know, we support the construction of those State VA nursing homes, two-thirds/one-third, and then we support the operation of it through a, per diem for veterans who are in there. We also have a contractual prerogative and, you would say, duty also, to see that they're being maintained at the acceptable standards. So, in order to ensure ourselves we're doing that, we inspect them. And, our inspectors found those deficiencies in those Colorado VA nursing homes that are run by the State, that are the responsibility of the State.

As to the specifics of those, I will defer to Dr. Kussman to respond.

Dr. Kussman. I'd have to get back to you, sir, with the specifics of all of them, but as the Secretary alluded to, we review these by policy every year, to go----

Senator Allard. Sure.

Dr. Kussman. And to review the State homes because the veterans in there are our responsibility. We will then recommend to the State home what we think needs to be done. Generally, it could be patient safety, or some construction issues or whatever.

Senator Allard. Sure.

Dr. Kussman. And, then we go back within 30 days to review that to see if they've done it. And, then the State is usually informed at the same time of that. Because, as the Secretary mentioned, they are State homes and they're responsible for fixing those things.

Ultimately, to protect the veterans, if the appropriate corrections aren't done, then we could refuse to send the per diem there and that usually gets everybody's attention.

Senator Allard. Yeah. Well, that's been my understanding, that you're going to do some follow-up inspections on these facilities and that's what needs to be done. I commend you for that. I just was curious as to whether there were things that were going to be easily corrected or whether we're looking at new facilities because some of those nursing homes are aging in time.

Dr. Kussman. I don't want to prejudice the response because I don't know the specifics.

Senator Allard. Yeah.

Dr. Kussman. But, generally they're relatively, not major construction issues, but how the patients are treated and other safety issues.

Senator Allard. What I'm going to do is have my staff get in touch with you. Is that appropriate? And, kind of share with us the nature of those. I don't know if we need to go into all the little specifics, but the nature of it and how easily correctable they might be. And, my understanding is that they, weren't affecting the healthcare of those patients that were in those facilities.

Okay.

Secretary Nicholson. We'd be happy to respond back to you with the detail of those inspections, Senator.

[The information follows:]

State veterans homes are owned, operated, and the responsibility of the State, in this case Colorado. VA provides oversight to assure safety and quality healthcare of the veteran residents in the homes through annual inspections and interim inspections as deemed necessary. The inspections review all aspects of healthcare, including direct observation of care and care practices, medical record review, resident interviews, physical plant, and sanitation inspections.

VA is aware of three press reports regarding State homes in Colorado. The following are the allegations in the press reports and the findings by VA and by State agencies addressing the allegations. The response addresses the issues noted in press release only and does not reflect the entire VA Annual Survey Report.

Failure to Report a Death of a Patient After a Fall

This report cited a 100 bed State home at Rifle, CO. Upon review of the allegation, it was found that the veteran did not fall. He had multiple medical problems and was admitted to a local hospital. This veteran died within 24 hours of admission from a massive intracranial hemorrhage. Massive intracranial hemorrhage is not necessarily associated with trauma to the head. A VA physician reviewer concluded that advanced directives were followed and the continuation of care and the decisions made were appropriate. The resident's wife was satisfied with the care he received.

42 Residents at State Veterans Home in Walsenburg Suffered Bed Sores

This report referenced a 120 bed nursing home at Walsenburg, CO. During the VA survey of September 2006, there were three residents in the facility with pressure areas. This VA annual survey found 42 incidents of pressure ulcers for the entire year. Not all were acquired in the State home. These were noted and treated. The facility has an appropriate mechanism for prevention, detection, and treatment. Pressure ulcers acquired in the facility are tracked and remain at 2 percent annual average, which is well below the national average. A focused review by VA on April 4, 2007, showed the facility at a rate of 1 percent acquired pressure ulcers.

Life-safety Issues and Accessibility Issues at a Home

A press article stated that twenty-five assisted-living ``cottages'' at the Homelake facility contain aging and defective electrical systems, asbestos and lead paint. They also lacked functioning emergency-response systems, according to State inspection reports. Most of those aging cottages lack ``grab bars'' in bathing areas, their front doors are not wheelchair accessible, and their narrow entrances and concrete stoops create tripping hazards for the elderly residents, according to the inspection reports.

These issues have been identified in VA annual survey reports for the past 3 years and increased emphasis has been placed on their resolution. VA indicators of compliance for State domiciliaries (standard 2c) State that--reasonable timetable (up to 5 years) is established for completion of corrective action for life safety deficiencies.

The major factor that limited the home's ability to correct these deficiencies was State funding. On March 1, 2007, the State provided additional information to VA to support a life safety determination for the project. On March 23, 2007; the project was determined to be a life safety project, based on the additional documentation. The State has certified State matching funds (good until 2010) and the project will be ranked as a life safety project on the fiscal year 2008 Priority List. Depending on the fiscal year 2008 appropriations, the project may be funded in fiscal year 2008. Separate from this request, an allocation of \$60,000 was made by the Department of Human Services so that work can begin immediately to correct the life safety deficiencies.

Senator Allard. Thank you.

You know, Madame Secretary, I think if we have any other questions we'll submit those for the record.

It's noon, I noticed. Mr. Secretary, I notice that we have pretty well ran them through the ringer this morning, so I thank you for allowing me a second round.

Senator Reed [presiding]. Thank you, Senator Allard.

Mr. Secretary, gentlemen, thank you for your testimony.

Mr. Secretary, you have a final point?

Secretary Nicholson. Mr. Chairman, if I might.

Senator Reed. Yes, sir.

Secretary Nicholson. As a matter of privilege I remain very proud of the people who work at the VA and how hard they work and how committed, dedicated they are to veterans. I received a couple of wonderful testimonials, unsolicited--under oath--they were unsolicited.

Senator Reed. That's why we did it, Mr. Secretary. So, you could verify it under oath. These are unsolicited.

Secretary Nicholson. But, if I could, I received and I'd like to enter them into the record.

Senator Reed. Without objection, they'll be entered into the record.

[The information follows:]

Prepared Statement From Disabled American Veterans

The news media recently uncovered a serious situation at the Walter Reed Army Medical Center in Washington. I am sure you have been affected by stories of neglect, abuse and the consequent overflowing frustrations of our wounded American military heroes that brought their plight so much national focus.

Like many, Disabled American Veterans (DAV), with 1.3 million service-disabled veteran members, was appalled and demanded that the Department of Defense immediately correct these deplorable conditions at its premier medical treatment facility. A Nation at war cannot tolerate bureaucratic delays, substandard housing and less than compassionate treatment of its soldiers and marines who have sacrificed so much while serving their country.

While media reports of the Walter Reed scandal have cast a shadow on military and veterans' medicine, I want to reassure you that DAV is very proud of you and the Department of Veterans Affairs (VA) healthcare system. Problems arise from time to time in any system that provides for the needs of large populations, but, at its root, VA healthcare is a constant and shining emblem of how to reform a system for excellence. Over the past 2 or 3 years we have seen mounting evidence that VA is a source of dependable, safe and efficient healthcare for veterans. The system provides a wonderful resource for sick and disabled veterans, that in so many ways is unique to our experience. You offer veterans the best quality at the least cost, and the lowest error rates of any healthcare system to which you might be compared. Your medication safety program, electronic health record and prevention programs are the envy of American medicine. VA serves the Nation's veterans well, while supporting and developing new generations of healthcare professionals and advancing the standard of care through its renowned biomedical research and development programs.

We, the members of DAV, want you to know that we consider VA to be a national treasure. While we may have experienced a momentary controversy brought about because one military medical treatment facility let down our disabled service members, we hold the Veterans Health Administration--and the work each of you do every day for sick and disabled veterans--in the highest regard. On behalf of DAV, I salute you.

Letter From Tom Poulter

National Headquarters,
5413-B Backlick Road,
Springfield, VA, April 4, 2007.

Hon. R. James Nicholson,
Secretary, Department of Veterans Affairs, 810 Vermont Avenue NW,
Washington, DC 20420.

Dear Mr. Secretary: In representing the 40,000 Patriot members of the Military Order of the Purple Heart, it is my honor to write to you concerning the overall condition and service of the Department of Veterans Affairs. For the record, the MOPH is very grateful for the assistance and service provided by the Department of Veterans Affairs and offers our continuing support to your staff and employees who do so much for so many. The Veterans Administration is ``World Class'' in my opinion offering patient care that far surpasses that obtained in civilian hospitals. This has been confirmed by studies done by the New England Journal of Medicine. I have yet to have one of my members complain about any care received by the VA. And we all remember how it used to be after Vietnam and as late as the early 1990's.

As a Veteran Service Organization, the MOPH is extremely pleased with the reaction time for benefit adjudication by the VA. In addition, we remain assured that any disability claim is treated in a fair and unprejudiced manner and that the disability ratings are for the most part commensurate with the claim of the veteran. No one can predict when a war will break out in today's environment leading to unplanned increases in the number of claims the VA receives. However, even with the overwhelming number of new claims, the VA is treating each with courtesy and respect and doing their very best to make sure the veteran is given every benefit to which he is entitled.

Further, as the VA plans and works under the budget as supplied by the Congress, we find no major areas of neglect in the physical properties. They are all well maintained and sanitary as befits the healthcare system. This is highly commendable considering that the VA is always working under a continuing resolution from Congress. I am the fourth consecutive National Commander of MOPH to ask the Congressional Veterans Affairs Committee for assured funding of the VA as our number one priority.

The one issue that we can all agree on happens to be the personnel of the VA. The MOPH believes that the employees of the VA are some of the best trained and most responsible people found anywhere in the U.S. healthcare system. Their concern for the veteran is evident in every contact made and every service provided. We praise you and your staff for providing us with the finest employees of any healthcare system in the World. And for that you deserve our most sincere appreciation.

Mr. Secretary, you and your staff are doing an excellent job with the Department of Veterans Affairs. If you ever require anything of us, please do not hesitate to call. We are all in total support of your efforts.

With Highest Regards,

Tom Poulter,
National Commander.

Letter From Linda A. Foss

17 Anchorage Rd,
Franklin, MA, March 11, 2007.

Dear Secretary R. James Nicholson: Due to the recent media coverage of the conditions at Waiter Reed, I feel I must get this letter to you.

My youngest sister, Luella Winne, had a right radical mastectomy with a trans-flap reconstruction at your Albany VA facility last April 17.

Being an R.N., B.S., with experience at several major medical facilities in Boston, I need to tell you that your facility destroyed all my preconceived expectations of a Veteran's hospital. I wish civilian facilities could be as efficient as yours.

On the day of surgery, we walked into your lobby to be greeted by many Senior veterans gathered and conversing. They greeted us with a smile and a tip of their caps. Luella responded with a ``Stand tall soldier. I sensed a deep camaraderie, that my sister responded to, that I would never fully understand. I am so grateful she has that support in her life.

I would like to state the fact that every employee (from janitor to physician) appeared to enjoy being there--it was wonderful to see and feel.

From a professional point of view, I was acutely observant of your medical staff. They never missed a step, from checking her wristband for identification, to lending a kind ear during this very emotional time. I have nothing but praise for your O.R., ICU, 5th floor surgical unit and the oncology infusion unit. Because of my sister's vegan lifestyle, your , dieticians were involved, daily, in her menu planning, which included many trips to a local health food store to accommodate her unique dietary needs.

Due to the 10 hour surgery, Luella was directly admitted to your ``state of the art'' surgical ICU. Late that evening, the Nursing

Supervisor came to me and offered me a room on the 9th floor so I could get some rest, I was amazed with the kindness I received that night. I would have napped in the waiting room, because my family's home was 90 minutes away.

Luella and I have returned several times for follow-up visits at the surgical clinic. Your clinic staff was responsive to all her needs with respect, kindness and compassion. The attention she received was not unique, as I observed their interaction with other Veterans as well.

Luella will continue her journey as a cancer survivor. She is still receiving chemotherapy, weekly now and her prognosis is excellent. The staff in the Infusion Unit is exceptional.

Your hospital is spotless. Much pride is visible in the manner in which Albany VA is maintained. So, I close knowing that Luella has such a wonderful gift in your facility. I have confidence that she could not have received better care anywhere else in my experience. Be proud of your staff, they are very special.

Thank you so very much,

Linda A. Foss,
R.N., B.S.

Letter From VADM Norbert R. Ryan, Jr.

Military Officers Association of America,
Alexandria, VA, February 12, 2007.

Vice Admiral Daniel L. Cooper (USN-Ret),
Under Secretary for Benefits, Department of Veterans Affairs,
Washington, DC.

Dear Mr. Secretary: On behalf of the 360,000 members of the Military Officers Association of America, I'm writing to express MOAA's deep appreciation for your rapid response to ensure expedited consideration of disability benefit applications from all injured OIF/OEF Veterans.

Your action has taken a major step to provide dignity and help to thousands of heroes who, through no fault of their own, would find themselves at great risk without this kind of support from their nation. Their service in the combat zone deserves every bit of assistance we can give them. The action of your Regional offices will ensure they receive that help.

All of us at MOAA express our thanks and gratitude for your national brokering strategy.

Sincerely,

Norbert R. Ryan,
President.

Secretary Nicholson. And, to just say that one was from the Military Order of the Purple Heart saying that, "The Veterans Administration is world-class," this is the President of this organization, "offering patient care that far surpasses that obtained in civilian hospitals. I have yet to have one of my members complain about any care received by the VA." And, it goes on.

And, another is from the Disabled American Veterans, from their National Commander saying that, "The VA healthcare is a constant and shining emblem of how to reform a system for

excellence. The VA is a source of dependable, safe, and efficient healthcare for veterans. We consider the VA to be a national treasure. And, we hold the Veterans Health Administration, the work each of you do every day for sick and disabled veterans in the highest regard.' That's signed by their National Commander. And, I appreciate the chance to put that in the record on behalf of our employees.

Thank you.

Senator Reed. Thank you, Mr. Secretary.

Senator Allard. Mr. Chairman.

Senator Reed. Senator Allard, please.

Senator Allard. If I might just follow-up on that. I don't think you were here when I made some of my remarks. But, you know, the American customer satisfaction index, they've rated better than the private sector now, they're on their seventh consecutive year. That's much better than their record was prior to 9/11. I think they're to be commended for that effort.

ADDITIONAL COMMITTEE QUESTIONS

Senator Reed. Well, I think that's accurate. I can reflect on the Veterans Hospital at Davis Park in Providence, Rhode Island and the spirit and the dedication to the veterans and the commitment to excellence is evident every time I go there. So, I accept those accolades for the record.

But again, Mr. Secretary, thank you for your testimony. Gentlemen, thank you, and thank you for your continued efforts on behalf of veterans.

Secretary Nicholson. Thank you, Mr. Chairman.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

Questions Submitted by Senator Tim Johnson

Question. The President's fiscal year 2008 Budget request recommends only a \$4.5 million increase for Vets Centers. In South Dakota, there is a high demand for the counseling and readjustment services these centers provide. For instance, South Dakota is a prime example of how important Vets Centers are to large rural States. Many veterans in South Dakota have to travel great distances to their local VA in order to receive counseling treatment, unless they can receive it at a Vets Center closer to home. Furthermore, the Department of Defense is using our National Guard and Reserve members in greater numbers than ever before. In South Dakota, 87 percent of the Army National Guard, as well as 74 percent of the Air National Guard, has been mobilized in support of our efforts in Iraq and Afghanistan. Finally, recent reports indicate that servicemembers serving multiple deployments may be at greater risk for being diagnosed with PTSD.

In light of the above considerations, is it realistic to believe this small increase is sufficient to meet the growing demand for the services that our Vets Centers provide?

Answer. The \$4.5 million increase for fiscal year 2008 represents the additional funding for only the first of two Vet Center program expansions approved by VA since 2006. In April 2006 VA approved of a plan to establish two new Vet Centers in Atlanta, Georgia, and Phoenix, Arizona, and to augment the staff at 11 existing Vet Centers. This

brought the number of Vet Centers nationally to 209.

In February 2007, we announced our plan to again increase the number of Vet Centers nationally to 232. Over the next year and a half, the Department of Veterans Affairs (VA) will be establishing new Vet Centers in 23 communities and augmenting staff at 61 existing Vet Centers. Our Vet Center expansion plans include augmenting the staff at the Sioux Falls, SD, Vet Center by one position.

When taken together with the program's additional 100 OEF/OIF Global War on Terror (GWOT) Outreach Specialists hired in 2004 and 2005, these program expansions have increased program staffing by a total of 269 positions from pre-2004 staffing levels. Based on these increases, and without cost of living adjustments added, the fiscal year 2008 budget for the Vet Center program will be \$125 million, which is a 25 percent increase over the program's fiscal year 2006 \$100 million budget. We are committed to effectively serving the increasing number of returning combat veterans and will evaluate the need for additional Vet Center resources on an ongoing basis.

Question. Last month, the Sexual Assault Prevention and Response Office (SAPRO) within the Department of Defense released the Military Services Sexual Assault Annual report detailing sexual assault in the military. According to the report, sexual assault reports increased 24 percent from Calendar Year 2005. Furthermore, it is commonly known that sexual assault victims are prone to developing post-traumatic stress disorder (PTSD). In addition, a recent New York Times Magazine article suggested that some female soldiers serving in combat have been sexually assaulted during their tour of duty. As a result, this select group of servicemembers--combat veterans who suffered sexual assault--may be at a higher risk for PTSD or the prevalence of PTSD symptoms will be exacerbated since they have been exposed to multiple traumatic events.

What is the VA doing to address the unique service-related needs of these women? What PTSD programs are available to women within the VA who have suffered sexual assault?

Answer. Every VA facility in the country has a designated Women Veterans Program Manager and a Military Sexual Trauma (MST) Coordinator. These are advocates who help women access VA services and programs, State and Federal benefits, and community resources.

In fiscal year 2007, VA's Office of Mental Health Services (OMHS) established a MST Support Team to ensure that VA is in compliance with mandated monitoring of MST screening, treatment, and education/training efforts and to promote best practices in the field. The MST Support Team provides regular feedback to the MST Coordinators and VISN-level MST Points Of Contact (POC) on facility MST screening rates and treatment of sexual trauma. The Team has launched several initiatives to promote provider competence in evidence based care including the monthly MST Teleconference Training Series and a National MST Clinical Training Conference scheduled for September 2007.

All VA medical centers provide mental health services to women. Additionally, every Vet Center has specially trained sexual trauma counselors. Nationwide, there are four specifically designated Women's Stress Disorder Treatment Teams (WSDTTs) located in Albuquerque, NM; Boston, MA; Loma Linda, CA; and Madison, WI. They are outpatient mental health programs specializing in treatment of posttraumatic stress disorder and other mental health disorders related to trauma exposure. An increasing number of other VA facilities have specialized outpatient mental health services and clinics for women and/or focusing on sexual trauma that are not formally designated as WSDTTs.

In addition to the outpatient care available at every VA, thirteen programs currently offer residential or inpatient setting-based treatment for sexual trauma-specific PTSD and other related disorders; at least two additional programs are currently under development. Programs range from those solely dedicated to the treatment of sexual trauma; to those with a special track emphasizing the treatment of sexual trauma; to those with two or more staff members with expertise in sexual trauma who, in the context of a larger program not focused on sexual trauma, provide treatment targeting this issue. Although some of these programs treat men as well as women, each makes accommodations to ensure they provide treatment sensitive to women's needs (e.g., separate living arrangements; women's only groups).

VISN 1

VA Boston HCS/Jamaica Plain Campus, Boston, MA: Women Veterans' Therapeutic Transitional Residence Program.

VISN 2

VA Western New York HCS/Batavia Campus, Batavia, NY: Women Veterans' Residential Program.

VISN 5

VA Maryland HCS/Baltimore Division, Baltimore, MD: Dual Diagnosis PTSD/Substance Abuse PRRP.

VISN 8

Bay Pines VAMHCS, Bay Pines, FL: Center for Sexual Trauma Services.

VISN 10

Cincinnati VAMC, Cincinnati, OH: Residential PTSD Program.

VAMC Dayton, Dayton, OH: Sexual Health Clinic and Domiciliary Program.

VISN 12

Clement J. Zablocki VAMC, Milwaukee, WI: Rehabilitation and Transition Unit--Trauma Track.

North Chicago VAMC, North Chicago, IL: Stress Disorder Treatment Unit.

VISN 15

VA Eastern Kansas HCS/Topeka Division, Topeka, KS: Stress Disorder Treatment Program.

VISN 17

VA Central Texas Veterans HCS/Temple Division, Temple, TX.

VISN 20

VA Puget Sound HCS/Seattle Division, Seattle, WA: Evaluation and Brief Treatment PTSD Unit.

VISN 21

VA Palo Alto HCS/Menlo Park Division, Menlo Park, CA: Women's Trauma Recovery Program.

VISN 22

VA Long Beach Healthcare System, Long Beach, CA: ``Renew''.

Question. The St. Louis Regional Processing Center is responsible for processing education benefits claims for veterans in South Dakota. Since early last year, I have received multiple reports from local veterans and school officials that processing delays continue to plague the St. Louis facility making it difficult for veterans to receive their education benefits in a timely fashion.

Furthermore, South Dakota has been reassigned a new Education Liaison Representative five times since 1999, the most recent reassignment occurring in October 2006. The South Dakota State Approving Agency values a strong working relationship with their Education Liaison Representative as it helps facilitate the claims process. However, the continued insistence on reassigning a new

Education Liaison Representative to South Dakota disrupts working relationships and the State Approving Agency's ability to provide timely assistance to our veterans.

Can you please provide an update on the status of claims processing at the St. Louis Regional Processing Center? If there is a backlog of claims pending, what resources does the VA need in order to eliminate this backlog?

Answer. Education claims receipts have increased during this school year as a result of the implementation of the Reserve Educational Assistance Program (REAP) and an increase in participation in the educational benefit programs.

The education workload at the St. Louis Regional Processing Office has been significantly reduced from 29,639 pending claims in late January to 7,632 pending claims as of April 30, 2007. The St. Louis RPO has also significantly improved claims processing timeliness from 41 days for original claims and 22 days for supplemental claims in October 2006, to 26 days for original claims and 11 days for supplemental claims during the month of April 2007.

The additional education program staff hired in 2007 and the funding requested in the 2008 budget will allow us to continue to improve performance.

Question. In addition, do you have concerns that the continued reassignment of Education Liaison Representatives (ELRs) will negatively impact the ability of State Approving Agencies to assist veterans as they access their education benefits?

Answer. The Education Liaison Representative (ELR) for South Dakota changed a number of times as a result of employee retirements. In October 2006, Ms. Loretta Tollin was assigned as South Dakota's new ELR. This is a long-term, permanent assignment. We are confident that the State Approving Agency will find her highly attentive to South Dakota's requirements, and she will strengthen their ability to timely assist veterans in South Dakota.

Question. The Capital Asset Realignment for Enhanced Services (CARES) decision approved construction for two new Community Based Outpatient Clinics (CBOCs) in South Dakota. These facilities would be located in Watertown and Wagner. It is my understanding that business plans are to be submitted to the VA Central Office for each proposed facility during fiscal year 2007.

Can you please provide me with a detailed update on the status of the proposed facilities in Watertown and Wagner?

Answer. Proposals for both were submitted in the last request for submission of business plans for CBOCs and are currently under review.

Questions Submitted by Senator Robert C. Byrd

Question. Mr. Secretary, what specific measures are the Department of Veterans Affairs taking to reduce the backlog of claims and when should we expect to see visible improvements?

Answer. VA faces many challenges in managing the disability claims workload and producing timely decisions. These challenges include:

- growth in disability claims received (up 38 percent since 2000)
- increasingly complex nature of the claims workload
- impact of expanded outreach efforts

We are devoting additional resources to claims processing. Increasing staffing levels is essential to reducing the pending

inventory and providing the level of service expected by the veterans we serve and the American people.

We began aggressively hiring additional staff in fiscal year 2006, increasing our on-board strength by over 580 employees between January 2006 and January 2007. With a workforce that is sufficiently large and correctly balanced, VBA can successfully meet the needs of our veterans.

Our plan is to continue to accelerate hiring and fund additional training programs for new staff this fiscal year--adding over 400 employees by the end of June. If we are funded at the level we requested in our 2008 budget submission, we will continue to add staff in 2008.

Because it requires an average of 2 or 3 years for our decision-makers to become fully productive, increased staffing levels do not produce immediate production improvements. Performance improvements from increased staffing are more evident in the second and third years.

We have therefore also increased overtime funding this year and recruited retired claims processors to return to work as reemployed annuitants in order to increase decision output.

We have deployed new training tools and centralized training programs that support more timely, accurate, and consistent decisionmaking. New employees receive comprehensive training and a consistent foundation in claims processing principles through a national centralized training program called ``Challenge.'' We have implemented an 80-hour mandatory training requirement for all employees.

We have implemented a ``brokering'' strategy to help balance the inventory of claims across regional offices. Claims that are ready for decision are sent from offices with high inventories to other stations with capacity to process additional rating workload.

We also established two Development Centers to specialize in ``brokering'' cases from other offices to assist in developing the required evidence and preparing cases for decision.

Our goal for this year is to reduce average processing time to 160 days (currently 177 days)--and to 145 days in 2008.

Question. We have been told that VA hospitals are juggling the books to make it appear that the time to get an appointment is shorter than it is. Allegedly, appointments are being made, then cancelled and rescheduled to make it appear that the time from making the appointment to actually seeing a doctor is shorter than it is. Are you aware of this practice? Will you look into it and respond back to me?

Answer. It is possible that a VERY small number of patients could have been taken off the wait list and later rescheduled. If this was done, it is contrary to policy and official procedures and is likely a result of employee error.

If information is coming from the OIG, we are visiting the sites where they found issues to determine the extent of the problem and to implement corrections as appropriate.

Question. Efforts at electronic record transfer between the Department of Defense and the Department of Veterans Affairs date back to the 1980s. What progress is being made in developing the capability to transfer electronic records between the departments?

Answer. VA and DOD have achieved a significant level of success and are currently using interoperable electronic health records that are standards-based and bidirectional to share clinical data. Pursuant to the Joint Electronic Health Interoperability Plan (JEHRI), our long term strategy to achieve interoperability, and the guidance and

leadership of the DOD/VA Joint Executive Council, VA and DOD are presently sharing almost all of the electronic health data that are available and clinically pertinent to the care of our beneficiaries from both departments.

VA receives these electronic data through successful one-way and bidirectional data exchange initiatives between existing legacy VA and DOD systems. These data exchanges support the care of separated and retired Service members who seek treatment and benefits from the VA and the care of shared patients who use both VA and DOD health systems to receive care.

Since beginning transfer of electronic medical records to VA, DOD has transferred data on almost 3.8 million unique separated service members to VA clinicians and claims staff treating patients and adjudication disability claims. Of these individuals, VA has provided care or benefits to more than 2.2 million veterans. These data include outpatient pharmacy (government and retail), laboratory results, radiology reports, consults, admission, disposition and transfer data, and ambulatory coding data. In 2006, DOD began transferring pre- and post-deployment health assessment data and post deployment health reassessment data on separated members and demobilized National Guard and Reserve members. Leveraging some of the technical capability to transfer records one-way, VA and DOD began the bidirectional sharing of electronic health records on shared patients. Data shared bidirectionally include outpatient pharmacy and allergy data, laboratory results, and radiology reports. This capability is now available at all VA sites of care and is currently installed at 25 DOD host locations. These 25 locations consist of 15 DOD medical centers, 18 DOD hospitals and over 190 DOD outpatient clinics and include Walter Reed Army Medical Center, Bethesda National Naval Center, and Landstuhl Regional Medical Center. VA is working closely with DOD to expand this capability and by June 2008, VA will have access to these data from all DOD locations. VA also is working with DOD to increase the types of data shared bidirectionally. Successful pilot projects demonstrated the capability to share narrative documents, such as discharge summaries and emergency department notes and this capability is now being used at four locations and will be expanded to others. Additional work scheduled for the remainder of fiscal year 2007 and 2008 will add data such as progress notes, problem lists, and history data to the set of information that is shared bidirectionally between DOD and VA facilities.

VA and DOD also have accomplished the ground-breaking ability to share bidirectional computable allergy and pharmacy data between next-generation systems and data repositories. This capability permits VA and DOD systems to conduct automatic drug-drug and drug-allergy interaction check to improve patient safety of those active dual consumers of VA and DOD healthcare who might receive prescriptions and other treatment from both VA and DOD facilities. At present, we have implemented this capability at seven locations and are working on enterprise implementation schedules.

Whereas our earliest efforts focused on the sharing of outpatient data, VA and DOD also have made significant progress toward the sharing of inpatient data. Most recently, we began sharing significant amounts of inpatient data on our most critically wounded warriors. Previously, these data were only available to VA from DOD in paper format. We have successfully achieved the capability to support the automatic electronic bi-directional sharing of medical digital images and electronically scanned inpatient health records between DOD and VA.

This effort has been successfully piloted, at least in one direction from DOD to VA, between the Walter Reed Army Medical Center and the four Level 1 VA Polytrauma Centers located in Tampa, Richmond, Palo Alto and Minneapolis. Clinicians at the Tampa and Richmond Polytrauma centers are routinely using it to view data on transferred patients. VA and DOD are finalizing a long-term strategy that will facilitate the expansion of this work across the enterprise systems of each department.

In addition to our joint work to share scanned documents and digital radiology images, VA and DOD have undertaken a groundbreaking challenge to collaborate on a common inpatient electronic health record. On January 24, 2007, the Secretaries of VA and DOD agreed to study the feasibility of a new common in-patient electronic health record system. During the initial phase of this work, expected to last between 6 and 12 months, VA and DOD are working to identify the requirements that will define the common VA/DOD inpatient electronic health record. The Departments are working to conduct the joint study and report findings as expeditiously as possible. At the conclusion of the study, we hope to begin work to develop the common solution.

Question. What challenges are created in treating Department of Defense patients in VA Polytrauma centers without the ability to transmit their records electronically?

Answer. As is commonly understood, much of the DOD inpatient data exists in paper format and is not available in electronic format. Without question, this creates some challenges. However, to ensure VA is fully supporting the most seriously ill and wounded service members who are being transferred to VA polytrauma facilities, VA social workers located in Military Treatment Facilities (MTF) ensure that all pertinent inpatient records are copied and transferred with the patient. Once the patient arrives at VA for care we are now able to support the automatic electronic transfer of inpatient data to VA clinicians who will treat these patients.

VA has successfully achieved the capability to electronically transfer DOD medical digital images and electronically scanned inpatient health records within VA. This effort has been successfully piloted between the Walter Reed Army Medical Center and three of the four Level 1 VA Polytrauma Rehabilitation Centers located in Tampa, Richmond, and Palo Alto. We are working now to add the fourth Polytrauma Rehabilitation Center at Minneapolis to this pilot project, and anticipate this will be accomplished soon. VA is also working to add this capability from Bethesda National Naval Medical Center and Brooke Army Medical Center to the four VA polytrauma centers. In the future, we hope to add the capability to provide this data bi-directionally in the event the patients return to DOD for further care.

VA and DOD also have established direct connectivity between the inpatient electronic data systems at Walter Reed Army Medical Center and Bethesda National Naval Medical Center and clinicians at the four Level 1 VA Polytrauma Rehabilitation Centers. These direct connections are secure and closely audited to ensure that only authorized personnel at the VA facilities access the electronic military data on the OEF/OIF service members who are coming to or who have transferred to the VA Polytrauma centers. VA and DOD are finalizing a long term strategy that will facilitate the expansion of this work across the enterprise in both departments.

Question. What is the status of the replacement of Department of Veterans Affairs' facilities that were destroyed by Hurricane Katrina?

Answer. The functions that were at VA medical center (VAMC)

Gulfport, MS, will be replaced at VAMC Biloxi, MS. VAMC Gulfport was destroyed by the storm surge. Several buildings collapsed. The facility was shutdown completely and secured. Recent activities include structural analysis for cleanup operations, records recovery, site cleanup, asbestos abatement and building demolition. At VAMC Biloxi, there are several phases of the major project in various stages of design. The first of these phases could start construction in late 2007.

The existing hospital location of VAMC New Orleans, LA, was determined to be too costly to reactivate. VAMC New Orleans replacement is awaiting land acquisition. VA has reactivated portions of the existing facility, as well as leased spaces in other locations, in order to provide outpatient care in the interim.

Question. Have you revised the headcount of VA patients to account for the current and projected casualties from Iraq and Afghanistan? What headcount was used in formulating the current budget request?

Answer. From the 2007 President's budget, we have revised our estimates to include the current and projected casualties for Iraq and Afghanistan. As reflected in VA's budget submission for fiscal year 2008, we estimate that we will treat over 263,000 OEF/OIF veterans at a cost of approximately \$752 million.

Question. In your opinion, how is the so called seamless transition between DOD and VA working?

Answer. Since its inception, the seamless transition program has achieved numerous accomplishments that result in great improvements toward the seamless transition of OEF/OIF service members into civilian life. The ability to register for VA healthcare and file for benefits prior to separation from active duty is the result of the seamless transition process.

VA/DOD Social Work Liaisons and VBA Benefit Counselors are now located at ten MTFs to assist injured and ill service members transfer healthcare needs to VA medical facilities closest to their home or most appropriate for their medical needs and to ensure that returning service members receive information and counseling about VA benefits and services. VHA staff has coordinated over 7,000 transfers of OEF/OIF service members and veterans from an MTF to a VA medical facility. Active duty Army Liaison Officers are assigned to each of the four VA Polytrauma Rehabilitation Centers to assist service members and their families from all branches of Service on issues such as pay, lodging, travel, movement of household goods, and non-medical attendant care orders. The Office of Seamless Transition established an OEF/OIF Polytrauma Call Center to assist our most seriously injured veterans and their families with clinical, administrative, and benefit inquiries. The Call Center which opened February 2006, is operational 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and their families. In addition, the Call Center has made 2,702 outreach phone calls to seriously injured OEF/OIF veterans, contacting 807 veterans since February 2007. Through these outreach phone calls, we have been able to provide these veterans additional assistance with outstanding health or benefits concerns.

VA has implemented an automated tracking system to track service members and veterans transitioning from MTFs to VA facilities. As part of this system, VHA implemented a 2007 performance measure to ensure that VHA assigns a case manager to seriously injured service members being referred from a DOD medical treatment facility to a VA treatment facility in a timely fashion. This performance measure monitors the

percent of severely ill/injured service members and veterans who are contacted by their assigned VA case manager within 7 days of notification of transfer to the VA system. During the period October 2006 through March 31, 2007, 152 severely ill/injured patients were transferred from MTFs to VAMCs. Ninety-five percent (144) were contacted by their assigned VA case manager within 7 days of notification of transfer to VA.

VA is participating in DOD's Post Deployment Health Reassessment (PDHRA) program for returning deployed service members. Since its inception, over 83,956 Reserve and Guard members completed the PDHRA on-site screen resulting in over 20,397 referrals to VHA facilities and 10,401 referrals to Vet Centers.

To ensure that OEF/OIF combat veterans receive high quality healthcare and coordinated transition services and benefits as they transition from the DOD system to the VA, VA developed a robust outreach, education and awareness program. The signing of a Memorandum of Agreement (MOA) between the National Guard and VA, in May 2005, and the formation of VA/National Guard State coalitions in each of the 54 States and territories now provide the opportunity for VA to gain access to returning troops and families as well as join with community resources and organizations to enhance the integration of the delivery of VA services to new veterans and families. This is a major step in closer collaboration with the National Guard soldiers and airmen. A similar MOA is being developed with the U.S. Army Reserve Command and the U.S. Marine Corps at the national level. VA and the National Guard Bureau teamed up to train 54 National Guard Transition Assistance Advisors who assist VA in advising Guard members and their families about VA benefits and services.

Building on these accomplishments, VA continues to monitor and improve the delivery of healthcare services and benefits to severely injured OEF/OIF service members and veterans. Toward that end, VA is addressing future challenges, such as expanding our web-based tracking application and integrating it with VISTAwEB and VA's Computerized Patient Record System (CPRS), and contacting all severely ill and injured veterans to assure their needs are being met.

Questions Submitted by Senator Patty Murray

Question. Secretary Nicholson, at a hearing 2 months ago, I submitted some questions for the record and I still not received a response. As you know, we can't provide what our veterans need if we can get accurate and timely answers from the VA. I would ask that you please provide a written answer to the following questions by Monday, April 23, 2007.

Answer. Responses to these questions were forwarded to the Senate Veterans Affairs Committee on April 20, 2007, and are repeated below for the record.

Question. Mr. Secretary, turning to Walla Walla, Washington--As you know, in 2003 the VA CARES Commission tried to close the facility that 69,000 veterans rely on. I worked with the community and the VA, and I appreciate you committing to build a new facility in Walla Walla. The community and I have some questions about the care that will provided in that new facility--particularly mental healthcare, long-term care, and inpatient medical care.
Mental Healthcare

Question. As you know, mental healthcare is not available in the surrounding community.

Can you explain how veterans in Walla Walla will get mental healthcare under your proposal? Also, how will they get drug rehabilitation?

Answer. The VAMCs in Walla Walla and Spokane will cooperatively manage inpatient mental healthcare for the Washington, Oregon, and Idaho counties in their service areas. This will include residential rehabilitation care for substance abuse and PTSD provided mostly at the Jonathan M. Wainwright Memorial VAMC in Walla Walla and through community contracts in Spokane. Inpatient psychiatry will be provided at the Spokane VAMC in Spokane, Washington, and through community facilities in Lewiston, ID, and Yakima and Tri-Cities, Washington. Expanded outpatient mental health services will continue to be provided at the VAMCs, the existing and planned community based outpatient clinics, and in other locations as determined.

Long-Term Care

Question. There is very little long-term care available in the region. You've made a commitment to me that long-term care won't go away before a new facility is built.

Will you continue to provide long-term care at the Walla Walla facility as long as it's needed, and will you commit to working with the State to build a State nursing home?

Answer. Long-term care will be provided at the Walla Walla facility or the surrounding community as long as it's needed. In regards to working with the State to build a State nursing home, VISN 20's network director, has recently requested that Walla Walla's new director work with the director of the Washington State Department of Veterans Affairs to begin the process of establishing a nursing home. Applications for VA grants to assist in the construction of State nursing homes for fiscal year 2008 must be submitted by August 15, 2007.

Question. How should vets who need long-term care today get it?

There has been no change in the provision of long term care at the Walla Walla facility at this time.

Inpatient Care

Question. Can you assure me that veterans in Walla Walla will not lose access to inpatient care as this transformation moves forward?

Answer. Veterans with service-connected conditions will continue to receive acute inpatient care in community facilities close to their homes. Walla Walla facility staff will ensure that the quality and accessibility of care are maintained.

Questions Submitted by Senator Jack Reed

Question. Secretary Nicholson, many of our troops have served multiple tours of duty in Iraq and Afghanistan, and have been deployed each time for months on end. I am growing increasingly worried about the strain that these multiple and increasingly dangerous deployments are having not only on the service members but also on their families.

The common consequences of combat--substance abuse, mental health disorders, and physical injuries--affect not just the service member but every member of his or her family as well. While the service member remains on active duty, their family members have access to counseling and psychiatric services through military healthcare system. But once

the service member transitions to the VA, there is no network in place to provide mental health assistance to their families.

I would expect that the percentage of Iraq and Afghanistan combat veterans with spouses and young children is significantly higher than in previous extended conflicts. Has the VA undertaken any assessment of the mental health needs of the family members of these veterans?

Answer. We agree that military families face a variety of stressors. Most families of deployed service members "rise to the occasion" and adapt successfully to this stressful experience. However, some service members who experience mental health disorders such as post-combat stress and PTSD may find reunification notably stressful (e.g., being startled by loud noises and disturbed by the chaos of a family with young active children). Thorough attention to service members and their family members' levels of stress and trauma is important for several reasons. First, increased stress in the family (especially tension and hostility) can trigger the veteran's PTSD symptoms. Second, family members who are hurt by the service member's behavior are often less supportive. This loss of social support is critical, as intimate relationships are a primary source of support for most people, and high levels of social support have been associated with decreased intensity of PTSD.

VA's authority to provide mental health counseling to family members is limited to counseling in connection with the treatment of certain veterans. As a result, we have not undertaken an assessment of the prevalence of the need for counseling.

Question. Psychiatric care and medications can be enormously expensive. Other than informal counseling through such services as Vet Centers, is the VA studying the possibility of extending mental health benefits to the families of Iraq and Afghanistan veterans--and if so, what statutory changes need to be made in order for this to occur?

Answer. Currently, the law permits VA to provide such counseling, training, and mental health services for family members as are necessary in connection with the care of a veteran receiving treatment for a service-connected disability (38 USC 1782). Family members of veterans receiving care for nonservice-connected disabilities can receive such services only if those services were initiated during the veterans' hospitalization, and continuation of the family services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

Question. Do you see this as an emerging problem, and what do you think the VA could or should do to screen and treat the spouses and children of combat veterans for mental health problems?

Answer. Many VA facilities offer mental health services such as family psycho-education and spouse education/support groups. Broadening the scope of VA's mental health services to spouses and children of combat veterans would have to be deliberated further.

Question. Secretary Nicholson, we know that on any given night more than 25 percent of homeless persons--nearly 200,000 people--are veterans. Already, some of these men and women are veterans of the current conflicts in Iraq and Afghanistan--although most of them are veterans from Vietnam, the first Gulf War, and peacetime service. In 2005, VA's own CHALENG Community Homelessness Assessment report identified a need for 25,000 new permanent housing beds and 12,000 new transitional housing beds to help these homeless veterans.

VA has effective programs that can meet these needs--the HUD-VASH supportive housing program that combines HUD Section 8 vouchers and VA supportive services for long-term homeless veterans with mental health

and/or substance abuse problems, and the Grant and Per Diem program that funds transitional housing to help homeless veterans get jobs and return to independent living. However, HUD-VASH has not been funded since the 1990's, and Grant and Per Diem funding is not keeping pace with the need for housing. Do you agree that these programs are effective, and if so, do you believe that this Committee should provide the VA with increased resources for these programs--so that the VA can ensure that no veteran becomes or stays homeless?

Answer. The number of transitional housing beds for homeless veterans has risen dramatically during the past 5 years, more than doubling the number of operational beds to more than 8,000 today. In addition we have already approved an additional 2,500 to 3,000 with the last three rounds of funding including the approximate 800 to 1,000 new beds to be created under a Notice of Funding Availability published on May 4, 2007.

After this round of funding is awarded, VA will have in operation or awaiting opening between 12,500 and 13,500 transitional housing beds. In addition we are in the processes of awarding funding to more than double the number of Special Needs grants to organizations that serve veterans with additional healthcare challenges.

VA has submitted a budget for 2008 that proposes to increase funding to further expand the capacity to offer services under the GPD program. Although funding amounts are still pending, it is expected that under the GPD Program for 2008, VA will be able to add to its current transitional housing bed capacity.

The HUD-VASH Program has approximately 1000 housing units in operation at the present time. There is still significant need for additional permanent housing for veterans and VA will continue to work with HUD and the Congress to meet that long identified unmet need.

VA remains committed working collaboratively with communities across the country to expand its capacity to serve homeless veterans with housing and other programs that will address the problems of homeless veterans.

Questions Submitted by Senator Kay Bailey Hutchison

Question. Mr. Secretary, I would like to compliment you again on the VA's successes in the area of electronic records. The VA's system is second to none, including the Department of Defense. It is a priority of this committee to see that our injured veterans receive world class care. We hear too often that the so called ``seamless transition'' is not seamless. A great many records are being lost between the time a soldier leaves the Department of Defense and arrives at the VA. The Department of Defense and the VA cannot electronically share medical records. I know you have several pilot test sites working on this problem. Why are the Department of Defense and VA not able to bridge this electronic gap? We are funding a working group that we hoped would fix this problem. I would like to see the Department of Defense adopt your electronic architecture to facilitate transferring records to the VA. Will you tell us where we are today and what are you doing to address the problem of sharing electronic healthcare records with the Department of Defense?

Answer. VA and DOD have achieved a significant level of success and are currently using interoperable electronic health records that are standards-based and bidirectional to share clinical data. Pursuant to

the Joint Electronic Health Interoperability Plan (JEHRI), our long term strategy to achieve interoperability, and the guidance and leadership of the DOD/VA Joint Executive Council, VA and DOD are presently sharing almost all of the electronic health data that are available and clinically pertinent to the care of our beneficiaries from both departments.

VA receives these electronic data through successful one-way and bidirectional data exchange initiatives between existing legacy VA and DOD systems. These data exchanges support the care of separated and retired service members who seek treatment and benefits from the VA and the care of shared patients who use both VA and DOD health systems to receive care.

Since beginning transfer of electronic medical records to VA, DOD has transferred data on almost 3.8 million unique separated service members to VA clinicians and claims staff treating patients and adjudication disability claims. Of these individuals, VA has provided care or benefits to more than 2.2 million veterans. These data include outpatient pharmacy (government and retail), laboratory results, radiology reports, consults, admission, disposition and transfer data, and ambulatory coding data. In 2006, DOD began transferring pre- and post-deployment health assessment data and post deployment health reassessment data on separated members and demobilized National Guard and Reserve members. Leveraging some of the technical capability to transfer records one-way, VA and DOD began the bidirectional sharing of electronic health records on shared patients. Data shared bidirectionally include outpatient pharmacy and allergy data, laboratory results and radiology reports. This capability is now available at all VA sites of care and is currently installed at 25 DOD host locations. These 25 locations consist of 15 DOD Medical Centers, 18 DOD Hospitals and over 190 DOD outpatient clinics and include Walter Reed Army Medical Center, Bethesda National Naval Center and Landstuhl Regional Medical Center. VA is working closely with DOD to expand this capability and by June 2008, VA will have access to these data from all DOD locations. VA also is working with DOD to increase the types of data shared bidirectionally. Successful pilot projects demonstrated the capability to share narrative documents, such as discharge summaries and emergency department notes and this capability is now being used at four locations and will be expanded to others. Additional work scheduled for the remainder of fiscal year 2007 and 2008 will add data such as progress notes, problem lists and history data to the set of information that is shared bidirectionally between DOD and VA facilities.

VA and DOD also have accomplished the ground-breaking ability to share bidirectional computable allergy and pharmacy data between next-generation systems and data repositories. This capability permits VA and DOD systems to conduct automatic drug-drug and drug-allergy interaction check to improve patient safety of those active dual consumers of VA and DOD healthcare who might receive prescriptions and other treatment from both VA and DOD facilities. At present, we have implemented this capability at seven locations and are working on enterprise implementation schedules.

Whereas our earliest efforts focused on the sharing of outpatient data, VA and DOD also have made significant progress toward the sharing of inpatient data. Most recently, we began sharing significant amounts of inpatient data on our most critically wounded warriors. Previously, these data were only available to VA from DOD in paper format. We have successfully achieved the capability to support the automatic

electronic bi-directional sharing of medical digital images and electronically scanned inpatient health records between DOD and VA. This effort has been successfully piloted, at least in one direction from DOD to VA, between the Walter Reed Army Medical Center and the four Level 1 VA Polytrauma Centers located in Tampa, Richmond, Palo Alto and Minneapolis. Clinicians at the Tampa and Richmond Polytrauma centers are routinely using it to view data on transferred patients. VA and DOD are finalizing a long term strategy that will facilitate the expansion of this work across the enterprise systems of each department.

In addition to our joint work to share scanned documents and digital radiology images, VA and DOD have undertaken a groundbreaking challenge to collaborate on a common inpatient electronic health record. On January 24, 2007, the Secretaries of VA and DOD agreed to study the feasibility of a new common in-patient electronic health record system. During the initial phase of this work, expected to last between 6 and 12 months, VA and DOD are working to identify the requirements that will define the common VA/DOD inpatient electronic health record. The Departments are working to conduct the joint study and report findings as expeditiously as possible. At the conclusion of the study, we hope to begin work to develop the common solution.

Question. Mr. Secretary, you now have over \$1.2 billion invested in Information Technology each year. A critical part of this will go toward upgrading VA's electronic medical records and VA's benefit processing systems.

What IT governance structure have you put in place to ensure that these critical priorities are aggressively and successfully pursued? Who is the one person you designated to be directly responsible for these technical programs to ensure they will be completely successful?

Answer. Over the last 18 months we have dramatically transformed the VA IT Management System. Significant parts of this transformation have been put in place in the last 6 months. Specifically:

- October 31, 2006, VA established a single IT leadership authority under the VA Chief Information Officer (CIO). This assigned the responsibility and accountability for all IT activities in VA to the Assistant Secretary for Information and Technology, the VA CIO. This ensured that there was a single focus for all Information Technology efforts at VA.
- On February 27, 2007, VA consolidated all IT staff and resources into a single organization; accordingly, consolidating the authority and responsibility for all IT efforts at VA. In addition, I directed that this new organization to implement success based processes for all IT efforts at a department level; therefore, ensuring that these critical priorities are successfully pursued.
- Finally, on March 12, 2007, the new IT Governance Plan was approved. The plan is intended to be an integral component to the VA Governance Framework and will serve as a mechanism to ensure compliance with all Federal IT mandates. It is a vehicle that enables VA to centralize its IT decision making. VA will be able to better align IT strategy to business strategy, maintain and develop the Enterprise Architecture, enhance Information Protection/Data Security, manage IT investments, and reconcile disputes regarding IT. IT Governance is the responsibility of the VA Executive Board, the Strategic Management Council (SMC) and other executive managers. While the VA CIO has full IT decision authority on all IT related

activities and issues, the VA business units have recourse to the SMC chaired by the Deputy Secretary and intimately to the Executive Board chaired by myself. This will ensure that IT efforts are focused on delivering services to our veterans and that critical priorities are aggressively pursued.

Our new OI&T structure, our IT Governance Plan and the implementation of ``core best business IT practices'' puts in place a robust VA IT Management System under the single IT leadership authority of the VA CIO. It provides the necessary oversight, safeguards, check and balances to ensure we achieve our IT objectives.

Question. Who is the one person you designated to be directly responsible for these technical programs to ensure they will be completely successful?

Answer. The Honorable Robert T. Howard, the Assistant Secretary for the Office of Information and Technology, and the Department's Chief Information Officer is designated to be directly responsible for technical programs and to ensure they will be completely successful.

Question. VA's claims processing backlog is currently over 400,000. And, you predict over 800,000 new claims annually. Yet, despite immense resources allocated for VA IT infrastructure, VBA continues to use old systems that require staff to re-enter information by hand. In the last 2 years the Veterans Benefit Administration has not been a priority in the Information Technology budget. I understand there are competing issues, but this is a critical mission of the VA.

How do you plan to make electronic claims processing a priority for the VA and identify opportunities for improved accuracy and automation in claims handling in fiscal year 2008?

Answer. Every year, more than 42 million disability compensation and pension payments are made to veterans and beneficiaries through the Benefits Delivery Network (BDN). BDN has been operational since the late 1960s, and the hardware and software that make up the system are obsolete. Each year the maintenance of obsolete technology becomes more expensive and more risky.

We are focusing our efforts on completing VETSNET, the replacement system for BDN. There are many reasons why the completion of the VETSNET system is important. VETSNET will ensure continuity of benefit payments to veterans and beneficiaries, and there are other advantages as well. The system makes veterans' claims information available on-line, which allows work on a claim to take place across regional office jurisdictions to better balance workload and provide improved customer service. Further, VA will be able to readily make software modifications to support improved work processes, legislative mandates, and security enhancements. It will also be possible to incorporate and enhance decision-support and ``expert system'' applications.

In addition to completing VETSNET, VA is conducting a pilot program to incorporate imaging technology into our disability compensation processing. Our pilot program involves claims from recently separated veterans filed through our Benefits Delivery at Discharge Program (BDD). We are receiving the veterans' service medical records electronically and are maintaining electronic claims folders for all claims filed under this pilot program. However, because of the magnitude of the paper records we store, the extent to which we can ``paperlessly'' process claims from veterans of all periods of service has yet to be determined.

VBA has been exploring the use of electronic, rules-based claims processing for certain aspects of compensation and pension claims adjudication. Electronic, rules-based claims processing technology

reduces variances among VA's regional offices, increases decision accuracy, and increases employee productivity.

VA is also using imaging to process adjustments to pension awards, and to manage workload. Paperless claims processing offers many benefits, such as increasing workload efficiencies, eliminating the need for storage of folders, and increasing customer satisfaction through the instant availability of imaged information. Through the use of our imaging system (Virtual VA) and the associated electronic claims folder, employees nationwide have the ability to instantly access claims information (service medical records, other medical documents, personnel records, and claims applications). Web-based imaging programs allow users to navigate and search for information faster than turning pages.

Question. What have you done to improve the accuracy and longer than average processing times for the Houston Regional Office?

Answer. As of January 31, 2007, the accuracy rate for benefit entitlement at the Houston Regional Office was 86 percent. In an effort to achieve the fiscal year 2007 accuracy goal of 90 percent, the Houston RO continues to take aggressive measures to improve the accuracy of claims processing. As of March 2007, Houston increased from six to eleven the number of senior Veteran Service Center (VSC) employees responsible for reviewing quality and evaluating training needs. These eleven senior VSC employees are dedicated solely to improving the accuracy of Houston RO claims decisions.

From the end of fiscal year 2005 through April 2007, the Houston RO has improved the average processing time of disability claims by 12 days, from 217 to 205 days. To assist Houston management with the development of a comprehensive plan for improvement, VBA sent a team to Houston to review critical elements of the station's performance and operations. The team recommended strengthening the workload management plan and providing additional training for claims processors.

The Houston RO has been given authority to hire additional claims processors in conjunction with the current national hiring initiative. The Houston RO had 286 FTE in its Veterans' Service Center at the beginning of fiscal year 2007 and is authorized to increase to 293 FTE. Four experienced claims processors are also transferring to Houston from other regional offices in the near future. The Houston RO also hired three retired decision makers whose sole responsibility is to process claims pending over 1 year or from claimants over the age of 70.

VBA continues to use an aggressive brokering strategy to decrease the inventory of claims across the Nation. Cases are sent from stations with high inventories to other stations with the capacity to take on additional work. This strategy allows the organization to address simultaneously the local and national inventory by maximizing resources where they exist. During fiscal year 2006, the Houston RO brokered nearly 5,000 rating claims, and the office continues to broker rating workload this fiscal year.

Question. I am searching for new and innovative ways we can help you solve this problem. One method your Under Secretary for Benefits, Admiral Cooper, has instituted is ``brokering'', or the practice of moving cases from Regional Offices with larger workloads to regional offices with a lesser load.

Can you tell us which regional offices have the highest workload per claims examiner and how this ``brokering'' has affected that office?

Answer. At the end of April 2007, the regional offices with the

highest workload per full time employee (FTE) were Detroit and Chicago. To assist these stations in reducing the number of pending claims and improving timeliness, VBA brokered cases from these offices to stations with additional capacity. During the first and second quarters of fiscal year 2007, the Detroit RO brokered 3,249 claims and the Chicago RO brokered 2,913.

Brokering plans are developed on a monthly basis. Stations are selected for brokering based on the percentage gap between their current inventory of pending claims and their established end-of-year inventory target. Stations with the greatest percentage gap are asked to send ready-to-rate cases to other stations for rating decisions. The stations participating in brokering changes over time as stations are able to bring the pending inventory in line with established targets.

Can you supply the subcommittee with a list of all Regional Offices and the associated workload per claims examiner?

Answer. See attached spreadsheet.

DISABILITY RATING CLAIMS

	March 2007 Decisionmakers	Ma P
USA.....	5,409	
Albuquerque.....	51	
Anchorage.....	18	
Atlanta.....	157	
Baltimore.....	63	
Boise.....	32	
Boston.....	51	
Buffalo.....	60	
Chicago.....	116	
Cleveland.....	182	
Columbia.....	136	
Denver.....	106	
Des Moines.....	35	
Detroit.....	97	
Fargo.....	25	
Fort Harrison.....	24	
Hartford.....	32	
Honolulu.....	32	
Houston.....	193	
Huntington.....	73	
Indianapolis.....	80	
Jackson.....	74	
Lincoln.....	58	
Little Rock.....	65	
Los Angeles.....	115	
Louisville.....	76	
Manchester.....	17	
Milwaukee \1\.....	177	
Montgomery.....	115	
Muskogee.....	140	
Nashville.....	144	
New Orleans.....	82	
New York.....	80	
Newark.....	47	
Oakland.....	128	

Philadelphia \1\.....	255
Phoenix.....	108
Pittsburgh.....	73
Portland.....	71
Providence.....	27
Reno.....	44
Roanoke.....	131
Salt Lake City.....	92
San Diego.....	139
San Juan.....	62
Seattle.....	139
Sioux Falls.....	20
St. Louis.....	142
St. Paul \1\.....	197
St. Petersburg.....	370
Togus.....	54
Waco.....	263
Washington, DC.....	15
White River Junction.....	10
Wichita.....	39
Wilmington.....	14
Winston-Salem.....	263

\1\ Pension Maintenance Center.

Question. We have discussed hiring more personnel, emphasizing IT solutions and now ``brokering''. We have to come up with something to relieve the pressure on the claims process and ensure our veterans have their claims processed in a timely manner. Can you offer any additional areas where we in Congress can help you with this problem?

Answer. In addition to enhanced technology and management practices, increasing staffing levels is key to reducing the pending inventory and providing the level of service expected by the American people and that our veterans deserve. We very much appreciate the support of Congress in providing the resources that are allowing us to aggressively add more decisionmakers in our regional offices. We increased our on-board strength by over 580 employees between January 2006 and January 2007. Our plan is to continue to accelerate hiring and fund additional training programs for new staff this fiscal year, adding 400 additional employees by the end of June.

The Veterans Disability Benefits Commission is charged with assessing and recommending improvements to the laws and benefit programs for disabled veterans. We look forward to learning the Commission's findings and recommendations for revising and simplifying our laws and regulations and improving the delivery of benefits and services.

Question. Mr. Secretary, your agency reports a \$5 billion backlog in facility maintenance. Every VA facility reported their maintenance condition which you relayed to Congress. Yet, the Facilities Condition Assessment you delivered to Congress was not in any priority order. I am concerned about working our way through this list giving the most critical problems the top priority. Facility directors often hold back maintenance funds till the end of the year in case they need additional funds for medical services.

How will you ensure that your facility directors spend all of the NRM funds as budgeted and appropriated and are incentivized to address the non-recurring maintenance projects?

Answer. VHA is currently working to alter the historical trends of NRM obligations and to normalize the obligation of NRM funds throughout the fiscal year. Annually VISN's submit an NRM obligation plan and a report is provided to the VA Deputy Secretary indicating the variance of actual and planned NRM Obligations.

Question. Mr. Secretary, as you know, this committee is interested in ensuring that our returning soldiers receive treatment for mental health problems as well as physical health needs.

What is the VA doing to expand access to mental healthcare for returning OEF/OIF vets at our new Mental Health Centers of Excellence?

Answer. Like other Centers of Excellence (COEs) within the Office of Mental Health Services, the new COEs in Mental Health and PTSD in Canandaigua, San Diego and Waco were established to support programs in research, education, and clinical care. In following this mission, their structure and processes are similar, in many ways, to the Mental Illness Research Education and Clinical Centers.

The COE in Canandaigua has a focus on the secondary prevention of adverse consequences of serious mental illnesses, particularly on suicide prevention. It has appointed Dr. Kerry Knox as its director, initial support has been provided, and Dr. Knox is currently leading the development of the program plan. While this is in progress, the COE is serving as a center for technical assistance and program leadership for VA national efforts at suicide prevention.

The COE in San Diego has a focus on understanding the processes of stress and resilience as well as vulnerability and recovery from PTSD and other stress related conditions throughout the adult lifespan. This includes pre- and post-deployment studies that are being conducted in collaboration with the Marine base and Camp Pendleton. It has appointed Dr. James Lohr as its director. He has led the development of a program plan that has been peer reviewed, approved, and fully funded. The Center is currently in the process of implementing its program plan. Its clinical activities include enhanced staffing for evaluations of returning veterans for deployment-related mental health conditions.

The COE at Waco has a focus on deployment and stress-related mental health conditions, and the transition between DOD and VA care. Its proximity and the ongoing relationships of its staff with the Army installation at Fort Hood is a major resource. It is currently in the process of finalizing the recruitment of its director who will lead the development of its program plan. Meanwhile, the Center has implemented its activities by initiated specific clinical projects. In one, Dr. Kathryn Kotrla is leading a partnership with the State of Texas in developing a web-based directory of mental health resources for returning veterans and their families and in training providers and others on its use. In another, the Center is working in partnership with the Office of Research and Development, and the National Center for PTSD to support a clinical trial of a care management strategy for primary care treatment of PTSD.

Questions Submitted by Senator Wayne Allard

Question. Many of my colleagues from States similar to Colorado face a challenge with bringing veteran's healthcare to rural communities. I hear from many veterans that live far from VA health centers with these concerns. Community Based Outpatient Clinics have helped to alleviate some of the geographical obstacle problems that

many rural veterans have, and Colorado has opened many new clinics in the past few years.

The VA announced earlier this year it was to place a clinic in either eastern Colorado or western Kansas, and I was told by VISN 19 in Denver to expect a final decision on the placement of this clinic by the end of this month. Do you have an update on that decision?

Answer. The lease for a community outreach clinic was awarded to the City of Burlington, Colorado on April 30. Congressional notifications were made on May 1, 2007. The location for the clinic is the Medical Arts Building, 1177 Rose Avenue, Burlington, CO 80807. It is anticipated that the clinic renovations will be completed and the clinic should open around October 1, 2007.

Question. Are there other solutions that the VA is attempting to address this problem of rural healthcare with?

Answer. Beyond establishing CBOCs, VHA employs other means to provide healthcare to veterans residing in rural areas. The strategic direction for providing services to veterans residing in rural areas is to provide non-institutional care and to bring care into veterans' homes. Examples of this are telehealth, mail order pharmacies, and home based primary care. We are setting the industry standards for using advanced technology with our telehealth healthcare delivery programs. With this advanced technology, we are providing services directly to veterans in their homes and expanding specialized care, such as specialized mental health services, in our Community-Based Outpatient Clinics (CBOCs) through telemedicine capabilities.

When a veteran needs to come to a facility, VHA has established outreach clinics which are part time clinics that operate under a ``hub'' CBOC. These allow for access in more rural areas that do not have the demand for services that a more urban area would have. Additionally, VA operates Vet Centers often located in rural areas that provide mental health services.

What about the challenges associated with Veterans that are in places deemed ``geographically inaccessible'' by the VA?

Response: VHA acknowledges that those veterans who live in highly rural areas have greater access challenges than veterans who live in urban and rural areas. To address this challenge, VHA has strengthened telehealth healthcare delivery programs. This includes implementation of a national care coordination home telehealth program (CCHT). CCHT assists in monitoring and treatment of common diseases/conditions of patients in their own homes. VA is leading the industry in telehealth application and research. VHA will further expand this program in efforts to address the access challenges of our veterans who reside in highly rural areas.

Questions Submitted by Senator Mitch McConnell

Question. I am deeply concerned about the details that have come to light regarding the quality of care provided at Walter Reed Army Medical Center. While not directly involving the Department of Veterans Affairs (VA), the news about Walter Reed carries with it important implications for the VA. I know you agree that both our brave soldiers and our veterans deserve the best possible care and that the situation at Walter Reed is unacceptable. In your response to a letter I sent you on March 6, 2007, regarding the quality of care provided to our veterans, you stated that you had ``directed that all facilities for

which [you are] responsible be inspected by management to assure that they are up to par.'

What criteria were used to make these evaluations?

What were the findings of this review overall?

Answer. Each VISN and facility was asked to provide a description of substandard cleanliness conditions (e.g. unsanitary conditions, peeling paint, and exposed wall and ceiling structures). Many facilities went above and beyond our expectations in reporting their issues. Specifically, a majority of the items reported were of a routine and recurring nature and items that you would expect to see at any medical center on a daily or weekly basis.

The Environment of Care (EOC) report identified 90 percent of the items as routine wear and tear for and included items such as paint repair, wall repair, and ceiling and floor tiles. Exterior items needing repair included sidewalks and doors, bathrooms, and light fixtures.

Nearly one-half of all items identified were addressed by March 30, with 85 percent of the items expected to be corrected by September 30, 2007. The remaining items represent larger ``wear and tear'' and infrastructure issues typical for healthcare facilities. Corrective actions have already begun on these with some being part of longer term existing projects and the remaining added to the facility's non-recurring maintenance (NRM) or major projects list.

VHA has had extensive oversight processes in place to assess and identify Environment of Care issues. Environment of Care walking rounds are conducted on a weekly basis in a specific area in facilities. The EOC rounds are led by the Associate Director and cover each area of the facility at least twice annually. Any findings noted on EOC rounds are tracked by facility leadership through to resolution. The Networks have also been directed to establish a VISN Environment of Care Team that will conduct unannounced visits at each facility at least once annually.

Question. I am particularly concerned about the nearly 360,000 veterans in the Commonwealth of Kentucky. I want to ensure they are receiving top quality healthcare from our State's VA facilities. Please provide a detailed description of the results of your findings for each Kentucky VA facility that includes both the criteria and your analysis of whether each facility meets acceptable standards for those criteria.

Answer. Each VISN and facility was asked to provide a description of substandard cleanliness conditions (e.g. unsanitary conditions, peeling paint, and exposed wall and ceiling structures). Additionally, they were asked to provide a plan for correction including timelines and the reason why the condition was not immediately correctable.

The findings within VISN 9 for Kentucky were limited to only one facility, the Lexington VA Medical Center. The findings were related to the need to replace carpet in three areas (primary care, medicine, and surgery administrative areas) and furniture in five areas (ambulatory/primary care, surgical care, intensive care unit, and emergency department waiting rooms, and a mental health unit group room.) All furniture and carpet issues were due to normal wear and tear. The plan for correction should be completed by July 30, 2007

Question. I was encouraged to see that the VA's Fiscal Year 2008 Budget Submission included the new medical facility in Louisville, Kentucky among the top-five priority major construction projects for the Veterans Health Administration.

Please explain the current status of this project, as well as your outlook for completion of this facility.

Is the March 23, 2007 announcement that the VA had completed its advertisement and evaluation process for selecting an architectural and engineering (A/E) team to provide full design services for the construction of the replacement medical facility an indication of the Department's commitment to complete this important project in a timely manner?

What deadline has the VA established for finalizing a contract with the selected A/E team?

If a deadline has not been established, when do you expect to finalize a contract?

When do you expect the site selection board to recommend its ``preferred site?''

Answer. As a result of the Capital Asset Realignment for Enhanced Services (CARES) process, a decision was made to plan for the construction of a new VA medical center in Louisville. At the present time, no funding is available for the acquisition of a site for this project. The site selection process, including conducting the necessary environmental impact studies will take about 1 year and will be timed to coincide with the ability to be considered for fiscal year 2009 funding consideration. This process is expected begin this summer.

In the meantime, the Department has selected an architect engineering firm as the designer for the project. The firm's initial work will include supporting the VA in evaluating sites identified through the search process and developing a space program for the project. Once a site has been selected, the firm will proceed into design. It is anticipated there will be individual contract actions with the firm for the start-up studies.

This project is one of several large project requirements identified in the CARES process and will be considered along with others for funding as future budget requests are developed. Site acquisition and design funding will be a consideration for funding in fiscal year 2009.

Question. I commend the Department, under your direction, for working to address the growing need for specialized care for veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom who are suffering from polytraumatic injuries. I am particularly encouraged by your recent action to expand this specialized care through 21 Polytrauma Network Sites (PNS) nationwide.

(a) What is the timeline for these PNS facilities to become operational?

(b) What services will PNS facilities, such as the Lexington VA Medical Center in Lexington, Kentucky, provide veterans recovering from polytraumatic injuries that are not available at other VA medical centers?

(c) In what ways will these new sites help reduce the strain endured by family members of severely wounded veterans?

Answer. (a) All 21 Polytrauma Network Sites (PNS) are operational.

(b) The PNS have dedicated interdisciplinary teams consisting of a physiatrist, rehabilitation nurse, psychologist, speech-language pathologist, physical therapist, occupational therapist, social worker, blind rehabilitation outpatient specialist, and certified prosthetist. The teams have received training in conditions associated with polytraumatic injuries including brain injury, amputation, visual impairment, pain management, and PTSD. They have also received training in the special needs of families and caregivers.

(c) The role of the PNS is to manage the post-acute complications of polytrauma and to coordinate life-long rehabilitation services for

patients with polytrauma within their VISN. As part of the Polytrauma System of Care (PSC), PNS are responsible for identifying VA and non-VA services available across the VISN to support the needs of patients and families with polytrauma.

Case management has a crucial role in ensuring lifelong coordination of services for patients with polytrauma and TBI, and is an integral part of the system at each polytrauma care site. The PSC uses a proactive case management model, which requires maintaining routine contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the case manager at the referring facility is responsible for a ``warm hand off'' of care to the case manager at the receiving facility closer to the veteran's home. Every combat injured veteran with TBI is assigned a case manager at the facility closest to his home. The assigned case manager handles the continuum of care and care coordination, acts as the POC for emerging medical, psychosocial, or rehabilitation problems, and provides patient and family advocacy.

A Polytrauma Telehealth Network (PTN) links facilities in the Polytrauma System of Care and supports care coordination and case management. The PTN provides state-of-the-art multipoint videoconferencing capabilities. It ensures that polytrauma and TBI expertise are available throughout the system of care and that care is provided at a location and time that is most accessible to the patient. Clinical activities performed using the PTN include remote consultations, evaluations, and even treatment, and education for providers and families

Question. The VA's 2004 Capital Asset Realignment for Enhanced Services (CARES) study recommended seven Community Based Outpatient Clinics (CBOCs) for VISN 15, which includes Daviess, Hopkins, and Graves Counties in Kentucky. Although the VA's budget request includes over 35 CARES major construction projects--several of which are CBOCs--none of the fiscal year 2008 CARES projects is located in VISN 15. More troubling, within the VA's Fiscal Year 2008 Five-Year Capital Plan, eight potential major construction projects for VISN 15 are identified, nearly all of which are to be located within Missouri, yet none of Kentucky's CBOCs in VISN 15 is included in that plan.

(a) Given that none of the three Kentucky CBOCs is registered on the VA's Five-Year Capital Plan, when can these communities expect to utilize the facilities they were promised?

(b) What options are the VA considering to ensure that veterans living in western Kentucky have access to quality healthcare close to home?

Answer. (a) There were three Community Based Outpatient Clinics (CBOCs) identified in the CARES study for Western Kentucky that are located in the VISN 15 service area. The Hopkins County CBOC, co-located at the Western Kentucky Veterans Center in Hanson, Kentucky, opened in August 2005. VHA is currently evaluating options, including CBOCs, to improve access in Kentucky.

(b) Veterans in Western Kentucky currently have access to three VA clinics in VISN 15. They may obtain care at the CBOC in Paducah, the Hopkins County CBOC, or the Evansville Outpatient Clinic. VHA is currently evaluating options, including CBOCs, to improve access in Kentucky.

Question. Regarding the construction of a planned 120 bed Utah State Veterans' Nursing Home in Ogden, Utah, about which my office has been in contact with the Department of Veterans Affairs, I am concerned about the prioritization of the facility. The nearest comparable facility located in Salt Lake City, Utah, continues to place an increasing number of veterans on a waiting list to which many of the veterans will not live to see an end. I would like to greater understand the process used in determining the order of construction of nursing homes in various States. For example, is a formula used that would continually place the needs of States with comparatively smaller populations of veterans behind more populous States? I would appreciate an in-depth overview of the decision-making process regarding construction of these facilities, with particular attention to the planned Utah State Veterans' Nursing Home in Ogden.

Answer. Projects submitted to VA for consideration under the State Home Construction Grant program are prioritized using criteria set forth in the law, as implemented by VA regulations in 38 CFR Part 59. In prioritizing projects, the law gives the highest ranking to those projects that are to correct life safety deficiencies at existing State Homes. The next highest priority is given to construction of new capacity in States that have a great need for nursing home beds. Title 38 CFR Part 59.40 identifies the maximum number of nursing home and domiciliary care beds for veterans by State. The limits are currently based on projected demand for such beds for veterans that are 65 and older projected to the year 2009. VA may participate in a construction grant to build new beds (up to 65 percent of allowable costs) in those States up to the maximum bed limits. There is a 2-hour travel time exception that may be approved by VA's Secretary. The annual fiscal year priority list is developed in accordance with the priorities set forth in the law, as implemented in title 38 CFR 59.50. A copy of the prioritization for priority group 1 and the first page of the fiscal year 2007 Priority List illustrate the development of the annual list. All initial applications and pending projects will be considered as of August 15, 2007, for ranking on the fiscal year 2008 Priority List. If a project is to be ranked in priority group 1, the State authorization for a project and the State 35 percent Certification of State Matching Funds for the project must be approved. Usually during September, the annual Priority List is approved by VA's Secretary. When Congress appropriates VA's fiscal year 2008 State Home Construction Grant budget, VA will inform the States with the highest ranking projects that funds are available for their project in fiscal year 2008. Annually, VA utilizes nearly all appropriated funds. To receive a grant, a State informed of the availability of funds must meet all the requirements for a grant award during the fiscal year. The proposed Ogden home will continue to be ranked on the annual Priority List until it receives a grant, unless the State elects to withdraw the application for funding.

[GRAPHIC(S) NOT AVAILABLE IN TIFF FORMAT]

SUBCOMMITTEE RECESS

Senator Reed. This hearing is recessed.

[Whereupon, at 12:03 p.m., Thursday, April 12, the subcommittee was recessed, to reconvene subject to the call of

the Chair.]

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